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ABSTRACT

This paper discusses how networks of elderly people change with stages of disability. Senior citizens in 80 nursing homes (40 in New York and 40 in Florida) were interviewed. The authors examine how spouses, relatives, neighbors, friends, and acquaintances help out when the elderly are robust, how these patterns of help change when the elderly become ill but still live in the community, and how, these patterns change when the elderly become institutionalized. The authors then show that the seemingly endless possibilities can be ordered and anticipated by the application of general sociological principles of the relationship of group structure to group tasks. The same principles can then be used by policy makers to evaluate and shape policy on "natural support systems" for the aged. (Author/RM)

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THE DYNAMICS OF NETWORK CHANGE FOR OLDER PEOPLE:

SOCIAL POLICY AND SOCIAL THEORY

by

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1980

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Columbia University
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and
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Introduction

In this paper, we should like to discuss how networks of elderly people change with stages of disability. More precisely, we want to show how spouses, relatives, neighbors, friends, and acquaintances help out when the elderly are robust, how these patterns of help change when the elderly become ill but still live in the community, and how, if at all, these patterns change when the elderly become institutionalized. What we hope to show is that the seemingly endless possibilities can be ordered and anticipated by the application of general sociological principles of the relationship of group structure to group tasks. These same principles can be used by policy makers to evaluate and shape policy on "natural support systems" for the aged.

The Meaning of Primary Groups or Natural Support Systems

We shall use the terms primary groups, networks, and natural support systems interchangeably. What the sociologists mean by primary groups is the opposite of the formal organization and has the below characteristics (Cooley, 1955):

(1) Internalized Non-instrumental or Non-economic Motivations. There are two internalized non-instrumental motivations usually attributed to primary groups. First, people in primary groups do things for each other because they feel the maintenance of the group is a very important goal in its own right. They do not help for individual economic gain. It is an internalized motivation, requiring no external supervision. (Etzioni, 1961; French and Raven, 1959). This form of compliance is often expressed as a "duty" to help.

(2) Primary group members are also motivated by their affection for each other. This is again an internalized group oriented motivation requiring no supervision. (French and Raven, 1959)

(3) Long Term Commitment. People in primary groups are often assumed to have long term commitments to each other--generally a lifetime. Thus parent and child ties are considered life time commitments. Marriage used to have this orientation, with vows stating "until death do us part."

(4) Continuous Proximity and Contact. Members of primary groups are supposed to be in continuous face-to-face contact as a total group, that is, they must be physically near each other as well as being in contact. In its ideal state they share a common household.

(5) Small Groups. Primary groups are small groups. They range from a two person marital dyad to extended kin or neighbors where one may have 20 or so people. Though there is a range in size, the largest primary group is still small by formal organizational standards.

(6) Diffused Relations. Primary groups legitimate activities in almost all areas of life, that is, politics, religion, art, family rearing, recreation, etc., as well as across generations. Primary groups are generally not thought to be specialized or delimited.

There are alternative ways of classifying primary groups (Parsons, 1951; Mitchell, 1973; Wirth, 1957; Toennies, 1940; Redfield, 1947). For the most part, it is our feeling that these are simply different ways of saying the same thing.[1]

What is most central about having an explicit definition of primary groups is the argument made by Litwak and Szenlenyi (1969)

and by Dono et al. (1979), that all exchanges provided by primary group members can also be classified in terms of these same dimensions. That is an extremely important point because it provides us with one of the basic principles for reducing the seemingly endless forms of potential exchanges. The principle being:

(I) Primary groups can best provide services which are consistent with their structure.

If there are five dimensions of primary groups there can be no more than five basic types of helping patterns or any combination of these five types instead of a seemingly endless number. Once stated, it may seem obvious, but the remarkable fact is that most investigators have never designed their research instrument with this thought in mind. Rather, the services being exchanged were chosen on some intuitive or haphazard basis.

Classification of Helping Patterns in Primary Group Dimensions. To make this point very clear, we shall discuss five of the dimensions of primary groups and show how they can be used to classify exchanges.

a. Continuous Proximity and Contact. To start with, all helping patterns can be classified in terms of the proximity they require. For instance, on a face validity basis we would argue that the following helping patterns would require very close continuous proximity: those cases where the caretaker helps the older person with daily grooming, that is, dressing, bathing, shaving, etc. Also included would be activities where the helper reporting attempted house breakins when the elderly are away on their daily chores, provided emergency first aid or an emergency loan of salt or sugar in the middle of a

meal, or kept "safe" keys if the older person lost their key or got locked out. By contrast, tasks which require only ad hoc proximity or no proximity at all are those where helpers provide emotional support by talking to people on the phone or helping older people make small household repairs, like fixing curtain rods or putting up a picture. These latter tasks could be handled by helpers who are far away or close by, while the first set requires people to be close by. There are still other tasks which require the helper to live a long distance to manage well. Thus providing non-uniform information on housing in a new city to which the elderly want to move, generally requires some primary group member who lives in that city.

All helping patterns can be classified in terms of the degree of continuous proximity they require or as performable under all conditions of proxmiity.

b. Degree of Long term Commitment. All helping patterns can be classified in terms of the length of time people have spent together or will spend together or as having no necessary relation to time. For instance, if an older person needs someone to pay their bills while they are away or in the hospital, or to keep track and deposit social security checks, they need someone who has a long term commitment. The reasoning is that money is a generalized means to most goals in a monied economy like the United States. The helper can use the older person's money for the helper's goals as well as the older person's goals. Furthermore, the control of the older person's money not only affects the older person's present activities, but can very much affect their future as well. Therefore, the managing of

money requires someone who the older person feels has a long term commitment (that is, they will take into account not only the present but the older person's future).

Also, any helping pattern that requires a large expenditure of time and resources generally will require long term commitments between people who operate an exchange of services rather than monetary payments. The reason being that reciprocity for such large expenditures of time and energy can be generally guaranteed only where people have a long term relation. For instance, if someone is sick in bed for two to three weeks and a relative comes to help with the home nursing for this period of time, the ill person will generally be able to insure reciprocity if there is a long term commitment. That is, in the long run the helper may be sick for two or three weeks or may require that magnitude of help.

Finally, long term commitment is required where help can only be given by those who have shared a common history or future. For instance, a wife who is upset by an incident which reminds her about a particularly poignant time with her spouse, might find that only her husband can provide her with emotional support because he is the only one who has undergone the experience with her.

In contrast, there are those helping patterns which require little long term time commitment (i.e., few economic or physical resources, not historical, and not involving money management). For instance, the neighbor who spots a burglary in progress at the older person's house and calls the police, will not need to have long term commitment. Nor the neighbor who loans a small household item, like a

bandaid for a cut finger, or the acquaintance who agrees to join a card game, or the volunteer who agrees to drive an elderly person to the doctor once or twice, etc., etc. To be precise, these latter activities could be handled by people with either a short or long term commitment while the former activities would require a long term commitment. There is still a third group of tasks which require short term commitment. Thus Simmel (1950) points out that people will only talk to strangers about certain problems (e.g., behavior negatively stigmatized by long term groups, like an extramarital affair). In short, all exchanges can be classified as requiring long term, short term or performable under conditions of either long or short term.

c. Diffused Relations or Same Generation. All relationships can also be classified in terms of whether the individuals engaged in them must share a common life style (that is, a specialized relation or diffused). Amongst the aged, it is our hypothesis that generational differences play one of the key roles in determining life style. Some tasks are diffuse in that they cut across generational lines and apply to all. Others are unique or specialized to older people. For instance, older people, because of retirement, have a major problem in accounting for time previously spent in work. In our society, we think of this as "free time" or "recreational time." Generally, older people seeking companions for "free time" must turn to people who share the same daily time patterns (i.e., other older people). Often if the activity requires matching physical reflexes or eyesight, or hearing, they also need someone from the same generation. Where older persons need everyday advice on dealing with problems unique to the

aged, such as handling prejudice against the aged, inaccurate social security checks, chronic ailments or widowhood, it is often the case that only those who have undergone these experiences can provide the practical everyday advice.

In contrast to these generationally specializing helping patterns, there are others which are diffused, that is, can be handled by people from the same or younger generation (for instance, cheering people up when they are low, help in keeping in touch with relatives, occasional help in purchasing food, occasional chauffering to doctors, doing small home repairs). There are still other tasks that require generationally younger people, such as tasks requiring physical and economic resources (i.e., lifting people in and out of bed or baths, heavy housekeeping or daily cooking or shopping). Given the age of our sample, we will classify our tasks into the two groups those which require helpers who are the same age (that is, 65 or older) and those which require helpers who are younger. We will not consider those tasks which may require some helpers who are younger and some older.

d. Small groups. All activities can also be classified in terms of the size of the primary group. A small group is defined as one person, or the marital dyad. A large group is defined as at least 3 adults or two households.[2] With this in mind, it is argued that there are many activities that can be best managed by one or two people in normal states of health, such as daily grooming, bathing, dressing, light housekeeping, managing money, daily cchecking to see if all right, etc., etc. Small groups are best for such tasks,

because little is gained by a division of labor and much is lost in flexibility

which require more than the individual or the marital dyad. For instance, all of the above would require more than the typical individual or marital dyad where an individual is very sick and can no longer perform them on their own. In addition, the emergency loan of a small household item like bandaids generally cannot be given by one spouse to the other because they share a common household. Emotional support where the problems arise because one spouse is sick or where tension arises from quarrels between spouses often require someone outside the marital dyad. Also requiring help from outside the marital dyad is information on everyday living which neither spouse has experience, such as information on problems of retirement for a couple about to retire, or shopping and social facilities for a person who has newly moved into the area, etc. Again the point can be made that all helping patterns can be classified in terms of whether they can be handled by smaller unit (i.e., by the individual or the marital dyad), requires more than the typical household unit, or can be managed by either.

All activities can also be classified by the degree of internalized motivation (i.e., affection and duty) they require. We would suggest where the outcome of the activity or the activity itself cannot be observed, it requires internalized motivation and cannot be managed by money rewards. For instance, where the elderly person is suffering from senility or any form of illness which reduces their motor activity and other senses, then help in personal grooming and ordinary household activities is very difficult to observe. If small

things are missing or if the helper is rough in handling the older person or if the older person's clothing appears in disorder, the helper who is paid can say the older person has misplaced the object, that the older person is imagining the rough handling, that the older person creates a mess as soon as they are dressed or that the older person is cantankerous and complaining. It is very hard for a third party to know if the helper is lying.

Similarly, if one hires a night nurse to watch over a sick person, it is hard to know how alert the night nurse is unless one is willing to stay up and watch her. If a person is put in charge of daily shopping, it is hard to know if they go out of their way to buy bargains or if they are engaged in petty pilfering. This is especially the case where food prices are continuously changing. If a burgler breaks in, it is hard to prove a neighbor saw him and didn't report it. If an older person falls down and calls for help, it is hard to prove a neighbor heard him and didn't respond.

By contrast, there are tasks that are easily observable, such as a person doing household tasks for a healthy older person who stays at home to supervise. In this paper we will not be examining this dimension of tasks systematically because most exchanges we studied required non-instrumental motivations. However, we bring it to the reader's attention because it is an underlying assumption in most of the analysis we make.

If the readers can accept the above distinctions in help patterns, then it becomes clear in what sense it can be argued that we now have a finite and a priori way of classifying all possible help

patterns. The seemingly endless number can be reduced to one of the combinations of dimensions suggested as basic to primary groups. Once tasks have been classified, then the principle of matching task and primary group structure provides a prediction as to which groups can optimally provide the help patterns.

Primary Groups Vary in Structure in a Modern Society

To proceed along these lines, it is necessary to know which forms of primary group structures are likely to exist in a modern society. Litwak and Szelenyi (1969) suggest a modern industrial society causes primary group structures to differentiate structurally into a few fixed types. The position states that in a modern industrial society, the demands of large organizations for rational allocation of labor, and appointment by merit, requires that people in the labor force be prepared for differential geographic and occupational mobility.[3]

What does this fact have to do with differential structures of primary group? As Parsons (1944) has pointed out, all things being equal, the primary group which is most effective in handling problems of differential mobility is that with the least number of people in the labor force--that is, the individual or dyad. Though we do not accept his complete argument (i.e., that primary groups cannot exist across geographical and social distances), he does indicate one of the most powerful institutional pressures to limit the size of the ideal household unit (i.e., it should be no larger than the marital couple with young children). In addition, Litwak and Figueria (1970) argue where tasks do not require the use of technical knowledge or large

manpower resources, the smallest possible primary group for a given task is the most flexible and speediest. For these reasons, there will always be an institutional pressure to maintain the two-person household unit.

As has already been pointed out, there are tasks which do require more manpower than the two person household. It has also been argued in partial contradiction to Parsons that primary groups in an industrial society can exist under conditions of differential geographic and occupational mobility (Litwak 1960a; Litwak 1960b; Sussman 1965; Sussman 1977). However, to do so they must modify their structure. Kin are basically defined in terms of long term ties by legal-biological definitions. Therefore they can not accommodate to differential mobility by altering their membership. Rather what they must do is waive the traditional primary group demand for continuous physical proximity and learn to exchange over long distance. In a modern industrial society this is possible because of modern means of communication. People can exchange many things over distance. However, this is no longer a traditional primary group and it differs from the marital dyad in at least two structural aspects, that is, size and continuous proximity.

Neighbors, in contrast, must have close physical proximity by definition. For them to survive under differential mobility, they must reject long term commitment while still retaining the capacity to exchange. This is possible if they develop very quick mechanisms of integrating people into the community (Litwak 1959; Fellin and Litwak 1963). This permits sufficient cohesion for exchange. However, it is

a structure which is very different from the traditional primary group. It lacks long term commitments. So far, we have three primary groups with very different structures. We are suggesting these differences are not accidental but directly related to the development of large scale formal organization in a modern society.

To understand the role of friends and acquaintances, it is necessary to take two related aspects of organizational structure into account. First, the large scale organizations are mostly based on science and technology and that means that different generations have different socialization experiences and have different styles of life. It is also the case in a modern industrial society that there is a degree of occupational specialization which has rarely occurred in past societies. If both factors are considered, each person may have some aspects of their style of life that is unique to their generation and occupation. Exchanges in those areas of life require someone who has very close matching characteristics. To find such people, it is necessary to have a primary group which provides each individual with great freedom of choice. The friendship primary group is historically the one which permits the maximum choice based on occupation and generational differences. Kinship and neighborhood groups do not necessarily insure that key people will have the same occupational and generational status. This is because occupations are based in part on merit while family is biologically or legally defined, and neighbors are based on proximity. That means there is no real guarantee that either group will share the unique occupational and generational characteristics of their members.[4]

What the analysis suggests is that unlike some past societies, modern industrial society puts institutional pressures on primary groups to differentiate. In addition, this analysis suggests that not all possible types of primary group structures are consistent with a modern industrial society. Thus, one type of kinship structure, the modified extended, is viewed as ideal (Litwak, 1965; Sussman, 1971), as is one type of neighborhood, the mobility neighborhood (Fellin and Litwak, 1963), and one type of marital structure, that permitting "role substitution" (Litwak and Figueira, 1970). There may, in fact, be many primary groups other than the ideal ones that arise, but the prediction would be made that they would perform poorly unless they have the same underlying structures as one of the ideal groups. Thus, communes which demanded long term commitment and close physical proximity would not function well (e.g., lead to lower standards of living, be short lived) or require heavy subsidization. Alternatively, if they grew to be a typical structure in our society, it would lead to a rejection of an industrial system based on rules of merit. Because the human mind is very inventive, we do not rule out the possibility that there may be many ways by which society can develop structures which resemble the ideal primary group, such as modified extended families. The key thing the reader must keep in mind is that there are institutional pressures for differentiating primary group structures and there are only a limited number of primary group types which are consistent with a modern industrial society.

Specific Functions for Specific Groups

We have pointed out that primary groups have different structures. If we argue that primary groups only can handle those help patterns that are consistent with their structure, it means each type of primary group has a unique set of helping patterns they can provide. To make that point clear, let us briefly review the type of helping patterns each can optimally handle. In this presentation we are appealing to face validity. In real life one of the major research tasks is to establish empirically the dimensionality of groups and tasks.

a. Unique Kin Helping Patterns. The kin as a group has the following structural features: it has large size (more than one person or marital dyad household), it has long term commitment, and it has both cross (e.g., children) and same generational (e.g., siblings) ties. What it generally lacks is continuous proximity, that is, marital units living in the same household or next door. If our propositions are right, this structure should optimally handle tasks which have these same properties. As suggested above, providing home nursing help for two to three weeks requires long term commitment (because it involves a large expenditure of time and energy), it requires large size because the spouse often does not have sufficient time and energy to provide that amount of care by themselves. It does not require continuous proximity, but only ad hoc proximity, that is, people can come from across the country to stay for three weeks and then go back. It does not require a common generation amongst the aged population, but may require a cross generational younger person. The reason being

that age peers amongst the aged may have limited financial and physical resources themselves; that is why friends cannot handle this task among the aged. Other tasks which have these characteristics are providing everyday emotional support when someone is feeling low about illness and wants someone to talk to who would make them feel better, paying monthly household bills, keeping track of social security checks, and managing bank accounts where the older person is away on vacation or sick in the hospital. All of these tasks often require resources larger than the marital dyad, they require some long term commitments, and they can be managed at some distance or by ad hoc visits.

b. Unique Neighborhhood Helping Patterns. Following the same logic, the typical neighborhood in the modern industrial society consists of a unit larger than the marital dyad household unit, it has continuous proximity, but no long term commitment. To review, a neighbor who reports an attempted burglary at the elderly person's house while the elderly person is engaged in daily household tasks is providing a form of help that matches neighborhood structure. The helping pattern requires someone who is in direct line sight of the home, it requires a group sufficiently large that there will still be someone watching when they perform their typical household or occupational chores. This task does not require someone with long term commitments, since in this case reciprocity is almost instantaneous and requires minimal individual resources. That is, the neighbor's house will also be watched by the older person and all one has to do is dial a phone. Some of the other tasks which are central to the elderly and fall within these dimensions of neighborhood are development of a neighbor-

hood "buddy" system to visually check people in their everyday routine, calling ambulances when neighbors fall down, loaning small household items, holding emergency keys for neighbors in case they are lost or stolen.

Helping Patterns Unique to Short Term Friend

What is meant by short term friends are people who share homogeneous status but have short term commitments. What is generally called for here are people who do not require continuous proximity, but do require more than the marital dyad, as far as size is concerned, and generally are from the same generation. Helping patterns amongst the aged who have these characteristics are the provision of companions for free time which do not require much in the way of long term commitment (e.g., someone to play an occasional game of cards), someone who might give information on a future program at a senior citizen center, someone who might give some information on the location of institutions which best provide special services for the aged such as special transportation discounts, special housing, special medical treatment (Horowitz, 1977), part time job opportunities (Granovetter, 1974), etc.

Helping Patterns Unique to Long Term Friends

By contrast, long term friends have long term ties. They are more likely to be people from the same generation. Many of the activities may resemble those specified above for the short term friend but have some significant differences. Where playing cards is part of a long term ritual, the card playing may be secondary to the

social occasion which in turn rests on a long term past association. Friends can give advice on matters which require some past knowledge of the personal history of individuals. Thus talking over with a friend whether one should move to a new location, the friend has sufficient knowledge of the personal idiosyncracies of the individual to know what kind of new places would be useful. Friends may share in planning a joint vacation or move together to a new retirement community.

Unique Helping Patterns of the Marital Dyad

What characterizes the marital dyad is that it can handle a wide range of exchanges, that is, long term or where time is not relevant, those requiring same generation or those that can be handled by either generation, and those requiring close proximity as well as those for which distance is irrelevant. The only thing which the marital dyad can't do is handle tasks which require more than the two adult household or tasks that require short term commitments (e.g., handling behavior which is negatively stigmatized by the marital dyad) or requires distance (e.g., provides information on potential new neighborhood).

To be specific, the marital dyad handles the problems of daily grooming which is a task which requires continuous proximity and long term commitments, and either same or younger generation. It handles the problem of payment of monthly or daily bills which is a task which requires long term commitment and same or different generation, and moderate proximity, but where small size permits flexibility in providing for unique individual tastes. It handles

tasks of ad hoc chauffering when someone has to make an unexpected visit to the doctor where time commitment, generation and proximity are not so relevant but small size provides the flexibility needed to handle such unexpected events. It handles problems of providing a companion (i.e., spouse) to fill one's free time recreational needs. Such companionship may require people from the same generation and with or without a long term commitment or continuous proximity. It must not be restricted to one sex. The free time activity can be occasional or continuous.

The idea that different primary groups have relatively unique functions is very consistent with a series of studies which shows that different primary groups do different things (Lopada, 1979; Rosow, 1967; Litwak and Szelenyi, 1969; Litwak et al., 1981; Adams, ; Babchuck, 1965; Muire and Weinstein, 1976; Cantor, 1979.

The Unique Helping Role of Institutions

Since the last stage of the health cycle consists of older persons who are institutionalized, it is necessary to indicate which activities will and will not be taken over by the formal organization as contrasted to primary groups. In this paper, we will not develop the general theoretical principles underlying this proposition since they have been developed in great detail elsewhere (Litwak and Figueria, 1970; Sussman, 1977). Rather we will state that formal organizations will only take over those activities from the primary groups for which it can be reimbursed and which can be routinized. The second proposition might be far less familiar to the reader. It simply points out

that formal organizations such as institutions for the aged are able to handle tasks which primary groups can't because it achieves economies of large scale by being able to break tasks down into simpler components so they can be handled more quickly, more reliably or with less effort. Alternatively, the division of tasks permits the development of specialists whose technical knowledge and machinery permits services no other group can provide. Most formal organizations achieve both types of economies. But nursing homes, unlike manufacturing firms, achieve their economies mostly by breaking tasks into simple components and routinizing them so they can be handled with least effort. Thus, in a large institution one person might be assigned the cooking functions, another maintenance, another the chauffering, another the bookkeeping, another the daily home nursing care, etc. The cook achieves economies of scale by being able to provide one basic meal for the majority of the residents. Thus if there are 300 residents in a home, the cook makes one meal for most of them. If the cook had to prepare an individual meal for each person (which the typical primary group will do), she would have to prepare 150 to 300 different meals which would be impossible for one person to do in the time allotted. Those in charge of making beds will have a fixed schedule for changing the sheets so they can change contiguous beds which means that those patients have to get up at a fixed time. In a similar fashion, one room can be used for recreational purposes of many if all have fixed times for use of recreational facilities. In general, one person can service many if the tasks can be routinized and clients scheduled to fit that routine. Where tasks cannot be

routinized, the formal organization generally cannot afford to handle them. People who do not like the standardized meals and want their own favorites will have to supply themselves.

Let us now return to the first proposition, that institutions will only provide for those services for which they are reimbursed. Generally there are three reasons why society will not reimburse a formal organization. First, for tasks which cannot be handled within reasonable costs because of extreme non-uniformity, e.g., providing individual meals. Second, tasks which cannot be supervised because of non-uniformity which may lead to exploitation of the older person. One of the central activities in this latter category is the supervision of the residents' everyday expense money. It is not often the case that the organization permits nursing home staff to have access to a resident's personal funds. The reason is that it is hard to keep track of money spent on daily household activities. It is too idiosyncratic. Staff could siphon off small amounts without anyone knowing. This contrasts with institutions like banks who are restricted in the way they can spend money to highly standardized procedures which can be easily checked.

Yet a third reason for society to restrict nursing home activities is because each activity requires added paid resources. Thus, even activities which can be standardized may not be covered by the institution unless it is viewed as very important. For instance, most nursing homes do not get reimbursed for storage of seasonal clothing or for cleaning personal clothing and sometimes for washing personal clothes.

Services which are typically either too non-routinized or which are not reimbursable are the following: everyday emotional support where people are feeling low and want someone to talk to to make them feel better; help in keeping in touch with relatives; managing money for personal expenditures; special food treats, special room furnishings to make the room homey; cleaning of personal clothing; storage of seasonal clothing; continuous supervision of everyday possessions to insure they will not be taken, etc., etc.

Sequencing of Helping Patterns and Primary Groups with Stages of Health

It is now possible, with the above conceptual tools, to present a theory of primary group sequences for the aged that parallels health-disability stages. The first step in the sequence consists of normally healthy marital household units and normally healthy supporting primary groups such as kin, neighbor, and friends and the tasks they perform. The second step will show what happens when the marital household unit is disabled and can only partially function in the community. In such cases, which of its tasks are consistent with each of the helping primary groups and thereby taken over by them? Which are inconsistent and lost? The third step in the sequence consists of marital household units which can no longer stay in the community because of severe disability and must be institutionalized. Which activities from the second step can institutions take over and which will be left to the helping primary groups and which will be lost?

Given the simplification provided by our theory, we will consider 5 sequences for each primary group (table 1). First is

"primary group expansion," where the support primary group takes over

[Table 1 about here]

tasks from the marital household at the second stage and continues through the third stage. The second is "partial expansion" where the support primary group takes over from the marital household in the second stage but where the institution in turn takes over from it. Yet a third pattern is called "primary group continuation" where the support group manages the activity in the first stage and continues through the other two as well. A fourth pattern is one where the support group handles the exchange in the first and second stage, but not the third. We call this "primary group decline." The fifth stage involves activities which do not fit any of the typical support group and consequently are lost. We call these "lost function." The claim being made is that once the helping pattern can be classified in terms of its theoretical dimensions, it is possible to predict which of the five sequences will occur. Though the five sequences do not exhaust all logical possibilities,[5] they probably are the most frequent and in any case will enable the reader to understand the logic of the approach.

The Analysis of Empirical Data

To show how this theory can be used, we should like to apply it to data gathered in a study of people 65 and older in the New York metropolitan area and Miami Beach and Fort Lauderdale area of Florida in 1978-79. Half the sample came from each area. Four hundred were taken from volunteers in randomly selected institutions for the aged.

The community sample was divided into four equal groups based on middle and working class areas and those living in age homogenous blocks (30% are 65 or over) or age heterogeneous blocks. Within each strata people were selected at random.[6]

For this analysis we will use only part of our respondents so as to highlight the theoretical issues. For the first stage we will take all those who are married and who have no disability or only minor ones. For the second stage we will take only those who are single and have major illness. In the third stage, we will basically take people in nursing homes who are very ill. We are excluding from this analysis married people with major illnesses, single people with minor illnesses and people in institutional living facilities who are basically healthy. The inclusion of such groups would not alter the findings but would make the pattern of the figures less distinct. Thus, married who are very sick and single who are healthy typically fall on all graphs between our stage 1 and stage 2 group. The only group which seems to follow a pattern of its own are the healthy people who live in institutions. (See appendix I)

a. <u>The Use of Primary Group Supports for Handling Marital Household Tasks</u>. To begin the analysis of sequences, let us review what tasks can be theoretically handled by the marital household. The task can require only one or two people, it can be handled by either the same or younger generation, but never just the younger generation. It requires continuous proximity or distance is not a crucial factor, but it can never require long distance. It involves either long or short term commitments but never just short term commitments. In Conceptual

Table 2 we have taken three dimensions of primary groups, dichotomized them, and suggested 8 possible combinations which describe a theoretical universe of marital dyad tasks. Ideally, this universe should allow us to classify all possible marital tasks and to indicate which, in principle, are consistent with other primary group or formal organizational structures and therefore can be picked up by them, which cannot be picked up by any of the typical groups in our current society, and what is the nature of new groups that would be necessary to pick up tasks not handable by present primary groups. The major limitation of table 2 is that we have presented only 3 of the four dimensions and have presented them as dichotomies when a several dimensional continuum might be in order. It is also the case that others have suggested more dimensions than the four we have suggested as characterizing marital primary life groups (Mitchell, 1973; Fisher, 1977). Despite these potential limitations, it is possible to demonstrate the explanatory power of describing tasks in primary group dimensions and then advocating the principle of matching group structure to task structure so as to anticipate which group will pick up when another fails, the reason being that the introduction of more dimensions and more complex classification may only provide a more detailed description but not contradict the simpler presentation.

[Table 2 about here]

With that in mind, let us consider the possible combinations in table 2:

(1) Do not require common generation or continuous proximity but does require long term commitment (e.g., keeping track of monthly social security payment).

(2) Does require common generation, and long term commitment, but not continuous proximity (e.g., advice on living patterns in a retirement village).

(3) Does not require common generation, nor long term commitment, but does require continuous proximity (e.g., providing temporary first aid and/or emergency chauffering to doctor).

(4) Does require common generation, in continuous proximity, but no long term commitment (e.g., older people getting together to get special escort services for elderly on their block).

(5) Does not require common generation, continuous proximity or long term commitment (e.g., occasional non-emergency chauffering such as planned visit to the doctor, to a concert, or to a sporting event).

(6) Requires common generation, but not continuous proximity, and long term commitment (e.g., non-emergency advice on how to deal with institution specializing in the aged -- social security, leisure time companions).

(7) Does not require common generation, but does require continuous proximity and long term commitment (e.g., daily grooming, feeding, dressing, housekeeping, etc.)

(8) Does require common generation, continuous proximity, and long term commitment (e.g., daily dinner or evening companion, who one can discuss events of the day and can relate them to a past and present life style.

What is important to stress is that most of the empirical activities carried on in the marital household unit can be classifies in terms of one of the above eight groups.

The question arises, what happens when the conjugal unit is incapacitated so it cannot manage these typical activities anymore? That in turn leads to the question, which primary groups have structures which overlap with the household unit in any of the eight ways described above? What is assumed in all these cases is that the primary group must be larger than the marital dyad. If we examine the eight types of tasks which the household marital

group can handle, there are two (that is, number 7 and 8 above) for which there is no typical support primary group with matching structure. Thus there is no typical primary group in our society other than the marital dyad that can handle tasks which at one and the same time require close proximity (same household) and long term commitments. We have atypical primary groups such as joint households where older persons live with their married children, friends, relatives or even acquaintances, if we consider communes. However, 86% of our community sample have no more than a single or marital household and 77% live more than 5 blocks away from their closest kin. Other studies of older people show similar distribution (Rix, 1979).[7]

It is, therefore, the prediction that tasks which require both long term commitment and continuous proximity will be lost for most of the population or given over to formal organizations with a partial loss because of the consequent need to routinize exchanges.[8]

When we say that the use of formal organizations will lead to a less than optimal solution, we mean that organizations must routinize their activities so that the older person gets standardized meals which do not match their idiosyncratic tastes. They will be served at times which do not match their idiosyncratic hunger pains, etc.

If we eliminate patterns 7 and 8, we have then six theoretical tasks from the original 8 for which one can find typical primary groups with matching structures. Since we are concerned with those who must be institutionalized, it is also necessary to ask which of these patterns is central to institution for the aged and routinizable.

That means each of the six patterns may or may not be followed by institutionalization. Therefore, there are 12 sequences of primary groups which we can examine when we consider our initial starting point as the marital household unit.[9] In the upper part of table 2, we have the six primary group sequences where in the last stage the tasks are performed by institutional staff members or not performed at all. In the middle of table 2, we have the same sequences, but where the institutions do not see the task as central or routinizable so that they are performed by the helping primary group network. In the bottom of the table we have the lost functions.

We will not discuss all twelve sequences, but only the three for which we have empirical data i.e., partial kinship expansion, full kinship expansion and lost function).

First, let us examine marital household tasks which can be handled by either those in the same or different generations, people in non-continuous or continuous proximity but requiring long term commitments. We would argue that such marital tasks are logically consistent with younger kin such as children, since they typically do not live next door and yet have long term commitment. There are four items from our survey which meet these requirements. First, we have an item which asked individuals if they had received any help in the last six months in monthly financial management, like keeping track of social security checks, household bills, or bank accounts. Second, we had an item which asked if anyone helped in the last six months with seasonal storage of their clothes, their laundry or cleaning. Third, we had an item which asked if anyone had helped them with fixing small

things around the house like putting up curtain rods, fixtures for pictures, and things like that. Finally, we asked them if anyone had helped with light housekeeping like dusting the rooms or making the beds.

What characterizes all of these items is that they are generally handled by the marital dyad (the smallest primary group) where people have normal health (Litwak et al., 1981). We think all involve long term commitment. Three of them (light housekeeping, fixing things around the house, and storage and laundry) involved a continuous expenditure of time and energy for a non-paid primary group member so that only someone with a long term commitment would undertake them on a regular basis, while the other involves managing money which, as indicated above, also requires long term commitment since one's future as well as present is affected. Therefore, we would say they all involve long term commitments.

What also characterizes three of the four items is that they do not require a common household or continuous proximity. Small household repairs like putting up a curtain rod is viewed as an activity requiring a once a month presence or less, while storage of seasonal clothes, cleaning and laundry are activities which vary between once a week to two or three times a year. All of these helping patterns can be managed by kin who can live between 5 block and four or five hours of driving time. The only item which implies more continuous proximity is light housekeeping. Its wording was sufficiently ambiguous so it can be interpreted as either a daily activity or a weekly one, e.g., making beds is daily while straighten-

ing up is weekly. Thus, what seems to be three and possibly four very diverse helping patterns with no relation at all, do in fact have three common underlying dimensions. As such, we should be able to anticipate by the theory of matching task and structure that typical kin can take over these tasks if the marital household unit fails.

But in order to make a complete prediction of sequences it is necessary to know in what respect these 4 helping patterns differ on the routinizability and centrality to institutions for the aged. We would argue that two of the items involve activities which are clearly reimbursable under U.S. governmental programs such as medicaid, and given the item wording can easily be viewed as routinizable events. Thus, handling light housekeeping such as dusting the rooms and making the beds and doing minor fixing around the place such as putting up curtain rods are both considered to be central duties of staff at nursing homes as well as routinizable. Given this classification, our conceptual framework (Table 2) tells us that these two exchanges (e.g., light housekeeping and small household repairs) will be handled by the household marital dyad when it is well and normal and by the kinship systems when the household unit is disabled but living in the community and by institutions when the older person moves to one. It is a sequence we have called "partial kinship expansion." If we look at Figure 1, we can see the anticipated curvilinear relationship between kinship aid and the stages of disability. That is, only13% to 20% of our respondents had kinship aid on light housekeeping and home repairs when they were healthy and married, this went to 31% and 41% when they were ill and living in the community and down to 6% and 9% when they were ill and single and lived in institutions.

[Figure 1 about here]

The data can also be presented as a regression equation (table 3) with the stages of health treated as dummy variables. In this case the constant represents the percentage of respondents who are healthy, who receive help from the kin while the unstandardized regression coefficient b_1 represents the difference in help received between the healthy and those who are sick and single but live in the community while the coefficient b_2 represents the difference between the healthy and those in institutions. Thus for home repair the small constant .19 and the larger positive b_1, 27 and small negative coefficient b_2, -0.9, represent a low-level curvilinear relation, typical of the partial kinship expansion (table 3).[10] For those receiving light housekeeping help these figures are c=14, b_1=20, and b_2=-07.

[Table 3 about here]

Their similarity to each other and distinctiveness from other patterns can be seen if we look at a pattern of "full kinship" expansion.

For this purpose, let us now look at the two items, money management and seasonal storage of clothes and laundry. They differ from housekeeping and home repairs in that they are not handled by the institutions. Handling discretionary funds is too difficult to account for in a routinizable way so that paid staff can be held accountable. It requires someone with an internalized commitment to the resident to handle such matters. It is also the case that medicaid will not reimburse nursing homes for storage of seasonal clothes and doing cleaning for residents' personal clothing. The larger society does not view this as central to nursing care.

Given these dimensions of the task, our conceptual scheme (Conceptual Table 2) suggests a pattern of primary group sequences called kinship expansion, that is, the move will be from the marital household unit in the first stage to kinship use in the second as well as the third stage. If we examine Figure 2, we can see it has a very distinctively different shape than Figure 1, that is monotonic, rather than curvilinear. Thus 14% of the respondents without disability have help in money matters and 16% have help in storage and laundry. This goes to 43% and 33% for those who are sick and single in the community. It goes to 51% and 47% for those who live in institutions. The above figures are represented in a regression equation (table 3) in which the constant for kin help in money management is .07, b_1 is 39 and b_2 is .47. The fact that both b_1 and b_2 are large and positive suggests the kin help at both the second and third stage. It can be seen that the key difference between the first two equations is in the b_2 coefficient or the third stage of institutionalization. As table 3 indicates, the b_2 for partial kinship is -.09 and -.07 while for full kinship expansion they are .47 and .31. Thus the average differences between the two sets of b_2 is 47 while the average difference between b_1 is 8 and the average differences of the constants is 07.

The stereotypes of family abandonment of older people in institutions is often so great that the theoretical prediction that families may increase some services (Dobrof, 1976, Dobrof and Litwak, 1977) to residents who are still mentally competent may be viewed as one of the startling predictions of this theory.[11]

[Figure 2 about here]

b. The Sequence of Primary Groups for "Regular" Non-Household Functions

What we have examined so far is the use of larger primary groups support systems which substitute for the marital household unit when it is disabled. Now we should like to consider tasks which are normally handled by non-household primary groups even when the marital dyad is complete and well. What happens to these non-household tasks when the marital household unit becomes permanently disabled? We think there are two possibilities. Where the task was done in conjunction with the marital unit (e.g., help in shopping when spouse is sick) then the larger primary group network will have to increase help to compensate for the loss. Where the task was done independently of the marital unit (e.g., loaning small household items in an emergency) then the larger support system may not be affected by the marital unit disability.[12]

Within these general considerations, we can examine normal helping patterns between healthy marital household units and supporting primary groups. The twelve possible patterns are displayed in conceptual table 4.

[Table 4]

What differentiates these 12 patterns from the first 12 in table 2 is that these start out in the first period with high exchanges from helping networks. Therefore, all patterns must be those of continuation or decline while patterns of expansion are less likely. Thus when speaking of activities which are normally handled by larger primary group networks, we will have three basic patterns associated with stages of health: "decline," "continuation" or "lost function."

These contrast with exchanges that are normally handled by the marital household unit, which we called "partial expansion," "complete network expansion," and "lost function."

We have two items which fit the kin "decline" sequence. The first asked the respondents, "Has anyone checked on you daily to see if you are all right during the last six months?" while the second is a hypothetical question which asks if the respondent is sick in bed for two or three weeks, who would help by bringing food, helping them in and out of bed, etc. What characterizes both of these helping patterns is that they often require a primary group larger than the marital household units. Both are activities which can be managed through ad hoc contact or by a telephone call rather than requiring close continuous proximity. Both require sufficient expenditures of time and energy so that only a person with long term commitments would undertake these activities on a non-payment basis. In short, both have in common dimensions which fit the structure of the kinship system. In addition, once institutionalized, both of these activities (as measured by our questions) would be considered central to the staff and routinizable.

If we examine figure 3, it can be seen that the married couple in the first stage of health (i.e., good health) has 33% who say they would use kinship for home nursing and 42% who said that kin had

[Figure 3 about here]

checked on them daily over the last six months. In the second stage of disability, these figures go to 48% and 57%. But in the third stage, where the institutions take over, these figures drop to 23% and

09%. In shape, figure 4 and figure 1 resemble each other. That is, in both cases the kinship system is used by a smaller percentage in the first and third stage to produce the curvilinear effect. Where they differ is the absolute height of the curve. That is, in figure 1, people at the first stage use kinship from 13% to 20% while in figure 4 people in the first stage use kinship between 33% and 47%. In both cases, the third stage led to a very low percentage saying kin do or would help. If we examine the regression coefficient and constant in table 3, the difference in the two sequences is apparent. Thus the constants (that is, the first stage) on the average differs by 27%, whereas the first coefficients, b_1 (second stage) differs by 07% on the average and the second coefficients, b_2 (third stage) differs by 15%. The big difference occurs with the constants of first stage. The similarity between the two figures, the shape of the curve, is represented by the same sequence of constant and positive coefficient b_1 and negative coefficient b_2.

Let us now turn our attention to the sequence of network supports we called (kinship) "continuation." The respondent uses kinship in all three stages of disability. This resembles "kinship decline" in all respects but one, the institutions do not see the tasks as central or routinizable. We have four tasks which fit this pattern. Respondents were asked if in the last six months anyone talked to them when they were feeling low and made them feel better. They were also asked if in the last six months anyone helped them keep in touch with their relatives, took them out for dinner or brought them special food, or bought them small items to make their place more

homey, like pillows and bedspreads or a television set. The way our questions were worded, two of the items are clearly non-routine tasks which the institution cannot manage, that is, providing resident special furnishing or providing resident with their own special food preferences. The institutions provide standardized food (with the exceptions being those on special medical diets). In a similar way, the institutions provide standardized room furnishing, with the residents expected to bring their own if they wanted to indulge in personal preferences.

Our other two items are not so obviously non-central or non-routinizable so require more explanation. Though some states provide money for social work functions, the usual ratio of one social work position to 100 residents means that they simply do not have time to provide the kind of everyday cheering up that our item implies. A social worker generally has a 35-hour work week in the United States. If there are 100 residents, the worker may have as much as 20 minutes per week for each one. If one considers that social workers have many more tasks to do than provide the kind of everyday emotional support for each resident, it can be seen in what sense our question taps a non-reimbursable aspect of emotional support. We would make the same analyses of keeping in touch with relatives. Staff aids can help by taking people to the telephone and helping them dial or writing letters for them. But in general, these are low priority items as contrasted to housekeeping and nursing functions of the aides.

If this analysis is correct, these four seemingly diverse helping patterns share in common the fact that they are supple-

mentary service to the healthy marital dyad, most of them can be carried out through the telephone or by ad hoc contact and, in general, they take enough time and energy so as to require some long term commitment by a non-paid primary group member. Again we emphasize how seemingly diffused empirical tasks can be grouped together by use of underlying theoretical dimensions (Conceptual table 3). What figure 4 shows is that this pattern of "kinship continuity" starts like the prior one with physically robust martial households having a high percentage of their populations using these kin services. The range

[Figure 4 about here]

goes from 40% providing household gifts to 68% using kin to talk to when they are feeling low. In the second stage of disability where the respondent is single and ill, the figures range from 47% using kin for household gifts to 79% who use them to talk to when they are feeling low. In the third stage, the range sinks slightly, going from 44% who received household gift to 71% who talk with relatives when feeling low. However, there are more people in the third stage using kin than in the first stage, even though the respondents in the middle stage are the highest users of all. Therefore we refer to it as "primary group continuity." If we look at the regression equation we find a high constant (on the average 51%), suggesting kin normally help healthy marital dyads, a positive but low b_1 (on the average 11%) and b_2 (on the average 07%). If we had a perfect continuation, then b_1 and b_2 should have been "0".

Thus far in our analysis we have concentrated on marital household and kin. However, our theory tells us that other supporting

primary groups have different structures and therefore different services to supply. We had two items which we thought would illustrate neighborhood services. The first asked if the respondent was out on their daily chores like shopping, who, if anyone, would spot a burglary attempt in their home and report it to the police. The second question asked from whom they could borrow a small household item, like sugar or a bandaid, in an emergency. These seemingly diverse tasks were classified as having the following theoretical dimensions in common: (1) they required close continuous proximity; (2) a larger group than the one or two person household; (3) could be handled by either the same or different generations; and (4) did not require long term commitments. What further characterizes these activities is that they are not likely to be accepted by the institutions for the aged as central and partially routinizable. Given these dimensions, we would expect a primary group sequence we have called "neighborhood decline." It resembles the pattern in figure 3 which we called kinship decline in two respects. In the first stage (that is, the robust marital household), there should be a heavy use of a supporting large primary group (i.e., the neighbors). This should remain constant in the second stage, and in the last stage there should be a very substantial decline in the use of supporting primary groups. As can be seen in figure 5, at the first stage (i.e., robust household units), 80% say neighbors will spot and report a "break in" and 74% say neighbors will loan small household items in an emergency. This drops slightly to 67% and 61% for each task when the members of the household unit are disabled and then there is a substantial drop to 34% and 36% when the older person is institutionalized.

To further illustrate the dynamics of network exchanges, data on acquaintances or short term friends will be examined. To do so calls for a consideration of primary groups established within institutions among residents. Though nursing home residents have the basic neighborhood features of proximity and short-term commitment, they also have a shared life style that is more typical of friends or spouses, e.g., same food, same recreational program, same staff to relate to, same generation, major disabilities, etc. If they are friends, it is likely they are short term friends with very limited resources or possibly resembled what Granovetter (1973) called "weak ties," and what we will call "acquaintances."

To summarize, institutions not only provide paid staff but they also provide the possibility for primary like groups whose structural characteristics are very similar to short term friends or acquaintances. If that is acceptable to the reader, we have the basis for discussing the pattern of acquaintance "continuation."

To measure exchanges amongst short term friends or acquaintances, we asked all our respondents the following question:

If you wanted someone to join you in your favorite free time activity, tell me which of the following people, if any (CARD A), would join you? (CARD A READS AS FOLLOWS: "Neighbors, close friends, children, relatives, husband/wife/companion, someone else (who?), no one." For those in nursing homes, the category of "aid" was added, and "residents" was substituted for "neighbors".)

We classify this question theoretically as requiring the specialized environment of a common generation given the retired

status of most of our population. The question does not say anything about whether these are short term or long term commitments. It gives the respondent discretion to take account of their physical frailties as well as their living conditions. Thus, those who have only short-term companions (i.e., live in institutions for the aged) may view the exchange as short term. It does not say anything about the extent to which the free time activity requires continuoue proximity or ad hoc contact. The fact of the matter is that as older people become more frail and poorer, their leisure time companions are generally people who live close by (Rosow, 1967). The assumption is that this form of help requires primary groups in addition to the household unit. According to our conceptual table 4, these are the characteristics of the sequences we called "acquaintance continuation."

The assumption is that in the robust healthy stage, a significant percentage will choose friends. As can be seen in Figure 6, 41% chose friends. This goes down slightly to 32% in the second stage of disabled household units and goes up to 49% choosing residents in the institutional stage. If we compare this "acquaintanceship continuation"

[Figure 6 about here]

sequence with the kinship continuation one, it can be seen that they share in common two features. In the first stage (i.e., the robust household), a substantial part of the population chose a group other than a member of their household unit. In the third stage, a very substantial number still chose a primary like group member.

Mixed Sequence-Household and Supportive Primary Group

Where the two patterns differ is in their overall shape. The acquaintanceship pattern is convex monotonic while the kinship expansion is concave curvilinear. The fact that our empirical data is related to the theoretical expectation in general, while having some unanticipated bulges and squiggles in particular, suggests that our items may in fact reflect some mixed pattern which we have not considered in our deliberately simplified theoretical statement. We should now like to consider some complexities. As mentioned above, there is no reason why in the robust healthy stage, the household unit and the supporting primary groups may not simultaneously share an activity since they have many of the same structural features except for size. For instance, home nursing care covering a two to three week period may be shared by a kinship unit and the spouse of the ill mate. The spouse cannot do it alone, but they definitely can play some role. By contrast, there are other services supplied by supporting primary groups which cannot be supplied by the spouse. Thus the item which asks who would you borrow a small household item from in an emergency eliminates the spouse, since the spouses and their mates share households and if one does not have the household item such as salt, neither will the other.

To predict the precise pattern of these mixed cases, one combines the predictions of the individual units (i.e., what one would predict if it were a kinship task alone and if it were a marital household unit alone). For instance, in the item on home nursing, one would predict a high use of the spouse but a lesser use of kinship

than would be the case if this was exclusively the realm of the supporting primary group. One would also predict a smaller use of spouse as contrasted to a service that could be only provided by the spouse.

If there was a case of mixed help in the first stage, then in the second stage one would predict an increase in the use of the kin or supporting larger network because the spouse could no longer provide help and therefore the demands on the kin would increase. If this were a service that initially was not provided by the spouse, the the loss of the spouse at the second stage may have no effect. In the third stage, one could again have a mixed response of kin and staff help. We would expect no kin help if the institutions took over the functions completely. However, if the kin share help with the staff so the staff took over in some cases, we would expect a dip but not a complete loss of kin help.

With this thought in mind, we can now address some of the differences between figure 3 "kinship decline" and figure 5 "neighborhood decline" in the second stage. Whereas kinship decline goes up at the second stage before declining, the neighborhood pattern is one of continuous decline. We think a major factor in the difference, is that our measure of kinship decline involved joint activity with the household unit while our measure of neighborhood decline did not. We can empirically demonstrate this because for 4 of our exchange items, we asked our respondents which groups did provide service, allowing the respondent to choose as many as they wanted. Let us examine for these 4 items how many of the respondents chose spouse at the first stage of health.

The two kinship items had 58% who said their spouse had checked on them daily in the last six months and 77% who said their spouse would help if they were homebound for two to three weeks. By sharp contrast, in the neighborhood items, 22% said their spouses would be able to watch their house when they were out on daily chores and 9% said their spouse would loan them small household items. In other words, it is the two items on kin that are most likely to be affected by a loss of the spouse in the second stage and therefore requires more kinship help if a "normal" level of support is desired. The neighborhood items are far less affected by loss of spouse in the second stage. We think this is what accounts for the large increase in use of kin in the second stage of the disability. They must replace the loss of spouse help: It also accounts for the small change for the neighborhood item.

The question arises whether the same phenomenon can explain the rise in the use of kin in the second stage of the pattern called kinship continuation (figure 4). We have a measure of the use of spouse for only one of the four items in this pattern (that is, who could you talk to when you are feeling low who will make you feel better?) Sixty-three percent use their spouse in the first stage of the health-disability scale. The loss of the spouse in the second stage would be significant and call for an increase, not just a continuation of kin aid.

In short, we are suggesting that many patterns assigned to primary groups as supportive of the normal healthy household units are actually jointly undertaken by both household and supporting

unit while others are uniquely in the sphere of the supporting or primary group or uniquely belong to the household units at the first stage. We are suggesting in the former case we get a blending of the two predicted patterns which generally lead to a rise in the use of the supporting primary group in the second stage of disability.

Can the same reasoning be applied for the third stage where there are again substantial variations in our predictions of decline, though the direction is very clear? We assume, but do not provide direct evidence, that exchanges are sometimes taken over by the paid staff (when central and routinizable). If in fact these two features are not dichotomies but continuous (that is, tasks have degrees of centrality or routinizability), then staff would have a degree of participation and it might explain the empirical variation we have in kinship aid at the third stage. We do have some direct measures of staff participation for some of these items.

First, let us contrast the items where primary group decline in the third stage (i.e., figure 1, partial kinship expansion, figure 3, partial kinship decline, and figure 5, partial neighborhood decline) with items where primary groups are active in the third stage (i.e., figure 2, kinship expansion, figure 4, kinship continuation, and figure 6, acquaintanceship continuation). According to our assumption, the first set should have more use of staff or paid help in the third stage than in the second set of items and they should have more use of paid help in the third stage than the first and second stages. We have eight items for which we had measures of staff or paid help. Four involved patterns of decline and four involved patterns of continuation.

[Table 5 about here]

What table 5 shows is that staff were more likely to handle exchanges in the third stage which was classified as decline or partial expansion. There were four items and they range from 30% to 94% of the respondents who received help from staff. By contrast, exchanges classified as "continuation" or "expansion" were in fact handled by paid staff less, that is, from 08% to 24%. Though these findings go in the right direction, it is also clear that the initial assumption had some errors. The differences between the lowest item in the first group (30%) and the highest in the second group (24%) is very small. It would be far better to view these items as being on a continuum of staff help rather than expressing a dichotomy.

If that is the case, then we can perhaps explain the dip that occurs in the third stage for those items that are called kinship continuation (figure 4). We have one item ("someone to talk to when feeling low") from the kinship continuation set for which we have measures of various groups who helped. It can be seen that 24% of our institutional population say they use staff or paid help as people they talk to when feeling low. Our view that this item measures a non-institutional task is correct in that this 24% is much lower than the 75% who use kin (table 6). Nevertheless, for some significant

[Table 6 about here]

part of the population (24%), there is a use of staff. We think this is in part the reason that there is a dip in the use of kin in the third stage (e.g., goes from 79% in the second stage to 71% in the third). It should be noted in the second stage only 01% use any form

of paid help or non-primary group members (table 5). It is also important to note that other items which measure kin continuation but exhibit no decline in help in the third stage are "managing money" and "having a free time companion." In those cases, the use of paid staff in the third stage is the lowest, 10% and 08%, respectively. The only real exception to our analysis involves the functions of storing clothes or laundry. Here we have no decline in kinship aid even when staff aid is as high as that for emotional support.

A secondary confirmation of the inverse role of staff aid and kinship aid can be seen in the terms for which the staff are thought to be appropriate when the older person is institutionalized. There is an almost perfect inverse rank order correlation between staff aid and kin aid (-.87).

What is central is that many of the seeming discrepancies in the original prediction can be understood once we are able to take account of the fact that we are dealing with mixed groups and a continuum rather than dichotomies.

The hypothesis developed under the assumption of simple dichotomies can be applied to a continuum as well. It is clearly a more complex measurement problem.[13] However, for many purposes, assuming a dichotomy or a very crude continuum with only a few points is sufficient for testing hypotheses or even devloping policy.

Atypical Groups and Exchanges not Examined

To have a framework for classifying all possible groups and exchanges has the virtue of permitting one to see what groups and what

patterns have been systematically omitted in any given study as well as suggesting theoretical possibilities that do not currently exist. In this paper we have pointed out that tasks which have the characteristic of requiring long term commitment and very close proximity are likely to be lost once the marital household is broken or disabled. We suggested this was true because there are institutional pressures in a modern industrial society that tend to mandate against the development of households with more than one major breadwinner other than the marital unit. However, it was pointed out (Litwak and Figueria, 1970; Dono et al., 1979) that these institutional pressures were much more moderate once people withdraw from the "labor force" (e.g., retirement, illness, going to school, etc.). Because older people are generally out of the labor force, they may have a higher percentage of joint households than most segments of the American population. They provide an opportunity to examine an atypical primary group as well as see how otherwise "lost exchanges" can be handled by such groups.

It is also the case that we have dealt with exchanges in a dichotomous way. If we think of these items as on a continuum (requiring degrees of long commitment and degrees of contact), it is possible to show what happens to exchanges as they resemble those which are thought to be lost.

a. Lost Marital Functions

The atypical primary group structure of a joint household can take over functions normally handled by the marital dyad and in addition can take on functions which otherwise become lost once the

marital dyad becomes disabled, because no other primary group combines the capacity for long term commitments and close proximity. To make this point, let us examine the household activity in our study which requires the most physical proximity--light housekeeping. This item referred to things like dusting of the room, the straightening of furniture and the making of beds. The latter is a daily event. The former might be a weekly event. In our prior analysis, we have stressed its weekly character. Now we want to stress its daily one. By contrast household repairs may be a monthly or even a yearly event. If we contrast light housekeeping with household repairs, we have two unambiguous items in which the first ranges from daily to weekly events while the latter ranges from monthly to yearly events. We think both items require some long term commitment, in that they are continuous, last over the life span of the individuals, and we are talking about non-paid exchanges.

What can be seen in figure 7 is that for those older persons who live more than five blocks away (Figure 7), only 8% of the population received help from their kin at the first stage of health. This goes to

Figure 7 about here

14% in the second stage and down to 6% in the third stage. It is a relatively flat line. For small household repairs, 13% of the respondents have help from kin at the first stage and this jumps to 30% at the second stage and then drops to 11% in the third stage. Between the first and second stages, the percentage of kin helping in light housekeeping goes up 6% while for small household repairs it goes up to 17%. If we were speaking about a lost function, then the percentage of kin

who helped should be extremely low at each stage and a straight line. The light housekeeping functions are most likely to follow that pattern where we are dealing with typical family kinship relations (i.e., live more than 5 blocks away). It is also the tasks which most clearly approach the requirements for daily contact and long term commitment. This point becomes even clearer when the typical kin structure is contrasted with the joint household (Figure 7). For joint household, there were virtually no differences in the percentage of respondents using kin for the two types of services and both services had very high percentages of respondents saying kin helped.

There is a whole class of activities which were not measured in this study which might well be lost in the second stage by those with a modified extended family or the nuclear family structure, that is, activities requiring close proximity and long term commitment. These are activities such as daily grooming, cooking, dressing, etc. The fact that typical supporting networks do not have structures to take over these tasks from the nuclear household unit will show up in households which are dirty, clothing which is in need of mending, poor nutrition, ill health, etc. For those who do receive help from formal institutions, e.g., meals on wheels, housekeeper service, we would expect routinized forms of help which would mean services would not be tailored to the clients' idiosyncratic tastes. It is also the case that formal organizations are really not set up to supervise subordinates in such non-uniform situations as home care and therefore we should have a much higher incidence of exploitation of the older person by service personnel as well as greater likelihood that the job would not be well done.[14]

We have touched on one type of lost function, that which involves long term commitments and immediate proximity. We think there is an additional type of lost function which arises when a formal institution takes over 24-hour care, such as in the third stage of disability. We are speaking about activities which require immediate proximity and non-instrumental ties, a dimension of primary group we have not explicitly considered until now.

What characterizes the typical third stage in our sample is that institutionalized older persons rarely had designated helpers who lived within five blocks of them (02% of our sample). Furthermore, it is the rare institution which permits people to come in whenever they feel like it. Both of these circumstances mean that any activity which requires very immediate primary group supervision can only be fulfilled by primary groups within the institution, that is, other residents or ties formed with staff.

We would argue that when the activity is a routinized one and central to the institution, like everyday household care for bedridden residents, it will not be lost. Where it is a primary group task that is based on a strong primary group (like a kin system) and is not dependent on proximity but can be carried out by phone or through the mail, it will also not be lost.

However, where the exchange is not central or not easily routinizable, or where the primary group is too disabled (senile or very sick) or too dependent or too fearful, then the helping pattern will be lost.

For 8 of our items we asked our respondent to indicate whether they received "no help at all." For 6 of these exchanges, such a response would mean a loss in function while for two of the exchanges the individual might handle the exchange by themselves.(i.e., manage money or manage laundry, etc.). We shall examine the six items where the answer "no one helps" clearly indicates a loss of function. If the reader will recall table 6, it had the percentage of respondents who used staff. We can use that table as a rough indicator of which tasks were handled predominantly by staff, which were handled predominantly by primary groups, and which were in the middle, not handled predominantly by either.

If our view is correct that those services are lost which require close continuous primary contact, then it must come from the middle group in table 6, tasks not handled predominantly by staff or primary groups, that is, having someone who will watch one's room while one was out, or someone who will be able to lend small household items like cologne for women or shaving cream for men.

If we examine Table 7, we can see the curvilinear relationship between task uniformity and the percentage saying the function is lost.

Table 7 about here

The lowest loss rate of 04% occurring for nursing care for bedridden residents, a uniform and institutionally central task as well as for a primary group tasks which can be handled on the phone (i.e., "someone to talk to when feeling low") where 16% said the exchange was lost.

The highest percentage of loss occurred with tasks that were in between, that is, not as central to the institution or not

routinizable, and requiring the use of a primary group in close proximity. Thus, 31% of the respondents said they had no one who would be able to watch their room and report a theft while the respondent was out on everyday activities, and 25% said they had no one they could borrow household items from in an emergency.

The item on guarding against theft provides a very good illustration of a task which requires a primary group in close proximity. First, the nursing home cannot completely routinized the function of guarding against theft. They seek to routinize it by suggesting all valuable be given to kin to store or be kept in the central office under lock and key. However, this does not help where theft involves possessions requiring daily use, such as cosmetics, articles of clothing, special room furnishings (e.g., radios), watches, etc., etc.

The problem arises because rooms are seldom locked, roommates are often strangers or too ill or senile to watch, the staff has free access to the rooms, and the potential victim is often confused and may not be aware something has been stolen.

More generally, we would say that there are a series of non-routinizable tasks which require close proximity and are likely to be lost in the third health stage.

Without trying to expand this analysis further, we would suggest that the theoretical classification of structures and helping patterns illuminates what kind of activity will be lost as well as what kind of group structure will be lost.

Economic and Social Cultural Factors

We have thus far proceeded with the analysis as though every individual had equal economic resources and more or less the same cultural values. At this time, we should like to point out that when such factors are considered, they add to the complexity of the analysis but do not basically alter the major sequences of primary group aid that accompanies each stage of health and disability. Rather than try to elaborate the full implication of such factors as family income, and ethnic-racial differences, we shall view them narrowly to show they do not modify the predicted sequence without trying to elaborate their unique role.

a. Family Income

In order to highlight the role of income, we shall combine all items which fall within a given health sequence. That is, all items which represent kinship decline will be represented as one item by taking the average responses for both items. Rather than having to look at 6 sequences and 13 items, we will now look at only 6 sequences. For each sequence, we will examine the income effect by looking at the respondent's family income. Older people were classified into three income categories which involved the lower one-fourth (those earning from zero to $2,999), the middle two-fourths (those earning from $3,000 to $6,999), and the upper one-fourth (those earning more than $7,000).

If one examines Figures 8 through 13, one has the 6 sequences and the three income groups. There are two basic empirical regularities which are of great interest. First, within each income group, the same general patterns occur which occur in the population as a whole.

However, there are some income differences as well. For people who are at the first stage of health, low income people always seem to have more help from the supporting networks than the wealthier people. However, as one moves to progressively worse states of health and to exchanges which can be handled over greater distances (that is, kinship expansion or continuation), the higher income groups do better and in some cases actually have more exchanges than the lower ones. In short, there is an income effect. However, since some of the key cells are based on very small numbers (13 cases), it is not clear how significant the effect is. If one contrasted working class sequential patterns with those of higher income groups, there could be some confusion on the partial kinship expansion versus kinship decline patterns. This confusion arises because working class families which are healthy have so much kinship aid.

The question arises how to explain the more frequent use of kin among the healthy poor and the reversal among the wealthier groups, and why the patterns reverse for those using neighbors and friends. We think there is basically one explanation for all these phenomena. We would argue that income relates to kinship exchanges in very much the same way as disabilities; that is, having a low income means that one has less resources to manage everyday household tasks. Thus a question which asks respondents if someone has provided a given service in the last six months might have very different meanings to poorer people than wealthier ones. For the poorer ones, it implies a greater magnitude of aid. Only groups which have long term commitments (such as kin) provide such substantial aid. This is especially the case

amongst the aged where friends tend to be age peers and also suffer from problems of disability and low income so cannot give aid.

Low income generally stands for low resources in two senses. First, those with low income cannot draw on formal organizations to provide supplementary aid to the family. People with money can purchase dishwashing machines and hire household help which makes the job of housekeeping considerably easier. They can make home cooking and food purchasing more convenient by paying for food delivery or by taking expensive but more accessible forms of transportation such as taxis or by purchasing at more expensive but closer stores. They can more easily and more frequently get emotional succor by virtue of being able to afford the expense of long distance calls. Money permits people to use formal organizations to carry out ordinary primary group tasks. People deprived of such income must put much more time and energy into handling everyday primary group tasks. As such, poor people, like the disabled, need more help.

How does one explain the reversals among neighbors and short time friends? These are both groups with either short term commitment or little resources (same age friend). All things equal, they cannot provide aid that requires large resources. Rich people are less likely to require large resources so they are much more likely than poor people to have exchanges with neighbors and friends; that is, they do not ask as much of them.

In short, being rich is like being physically healthy; it provides one with greater resources and as such follows a logic of kinship exchange which parallels that of the health stages, but does not

contradict it. To spell out the unique patterning of each and the simultaneous interaction of both will not be developed here, though the

Tables 8 to 15 about here

reader can get a sense from the overall patterns suggested above, that economic and physical disabilities contribute independently to exchanges. To get some idea of the effects of income on the shape of the predicted trends, we include income in the regression equation. One can see the size and direction of the coefficient remaining virtually unchanged when income is added. Only the constants seem to exhibit a systematic change (table 8). Since the constants in this case include healthy

Table 8 about here

married with low income, they reflect the fact that low income groups receive more help in the first stage of health than other income groups, as reflected in Figures 8-13 and discussed in the text above.

b. Ethnic Racial Considerations

There is one final element which might influence primary group sequences, and that is ethnic-racial norms. Because of the peculiarity of our study population, that is, people 65 and older in the New York City metropolitan area and the Miami Beach area, we have an unusually heavy Jewish population. It is possible that some of our findings might be affected by this fact. Amongst our population, 33% were classified as native Americans in that they and all of their grandparents were born in America and they did not identify with any ethnic group nor as being from a Jewish religion or faith. Fifteen percent came from English-speaking countries or from Western Europe, 10% came from East Europe or Mediterranean countries, 06% came from Latin

American or Caribbean countries, 06% were black, 29% were Jewish, and 1% couldn't be classified.

It is of some interest to know if the patterns we have discovered were the same for each group. First, we would note in 9 of the 10 kinship exchanges, the hispanic, East European and blacks were more likely to use kin than the other groups (table 9). On the average, the former group had 13% more choosing kin than the Jewish,

Table 9 about here

assimilated and West European groups. It is also the case that assimilated, West European and Jewish groups tended to live the furthest away from their kin and the hispanics, East Europeans and blacks lived the closest. The former group had on the average 76% of the respondents living more than 5 blocks from their helpers, while the latter group had 55% living 5 or more blocks. The latter group is also poor, with 34% of the hispanics, blacks and East Europeans being in the lowest quarter of the income distribution. By contrast, the assimilated et al. had 14% in this lowest income bracket. This could well account for a large part of the difference in exchange, since proximity and low income both increase exchange. However, that in turn raises the question, why the assimilated, West European and Jewish groups live further away. Is that part of cultural norms or racism which prevents mobility? In short, what causes what, proximity and income or ethnicity? To unravel this issue would require a complex analysis which would lead us away from our major focus. Rather, at this point, we only note that there are ethnic differences without trying to explain them. They could be a

function of low income or geographic proximity and only spuriously related to ethnicity. Or they could reflect basic ethnic values towards family life. Regardless of the cause, these ethnic differences generally do not lead to different sequencing of primary group support with reference to stages of disability. That is, within each ethnic group, the same patterns of partial kinship expansion, complete kinship expansion, kinship continuation, and kinship decline appear. (Figures 14-19).

There are some differences amongst the hispanics, blacks and East Europeans with regard to kinship continuation. When the older

Figures 14-19 about here

parents are institutionalized, they move towards kinship decline rather than kinship continuation. Thus, hispanics and East European groups are not as likely to provide seasonal storage of clothes or manage finances for parents in nursing homes. Similarly, they tend to provide less support than others for helping institutionalized aged keep in touch with relatives, enjoy special meals, or furnish their rooms in a homey way. All other groups continue or increase their kinship aid for institutionalized elderly in these exchanges. One reason for this difference is that these ethnic groups may have less experience in dealing with institutions for the aged. Thus only 12% of the East Europeans have people in nursing homes and 10% of the hispanics, as contrasted with 28% of the Jewish groups. 21% of the Western Europeans, and 23% of the native Americans. However, the blacks do not provide for institutionalized aged and they have experience with institutions, that is, 36% have institutionalized aged.

Another possible explanation is that hispanics and East Europeans tend to live closer to their parents and tend to take care of them rather than send them to a nursing home. Those who end up in a nursing home may have helpers who are not children and are less devoted as a consequence. This group may contain a large number of recent first generation migrants, if one argues blacks from the South are also migrants. As such, we may have a special group without children nearby. Yet a third explanation is that these groups espouse a traditional kinship norm and as such do not know how to work with formal organizations. We offer these speculations but will not pursue them in this paper to systematically study the effects of ethnicity.

The overwhelming fact is that for the bulk of the people and for the bulk of the items, the patterns of network change suggested at the beginning of the paper hold, with minor exceptions, amongst all ethnic-racial groups. We have presented a regression including ethnic groups as dummy variables with the constant now measuring assimilated Americans in the first stage of health. It can be seen that the basic size and direction of the constants and coefficients are not affected by the introduction of ethnic groups. It is also the case that the hispanic, East Europeans and blacks seem to provide a unique contribution (table 10). Furthermore, if one includes both

Table 10 about here

income and ethnicity into the regression, it does not affect the pattern of constant and coefficients. It does suggest the ethnic factor may play a larger role than income, since income effects seem to shrink to the point of insignificance once ethnicity is introduced. However,

in our view it would be very risky to make too many inferences until one could unravel the causal relations between income, ethnicity, and proximity and until one had better measures of each.

Social Policy Evaluation

Given the above theoretical and empirical statements, there are several major implications for policy evaluation. Policy makers are frequently faced with a plethora of programs, and seemingly endless exchanges between primary group members as well as many different support groups. It often seems like an impossible task to match programs, support systems, and exchanges in any rational manner. Rather, what seems to happen is a series of bright ideas leading to programs which seem to provide an ideal solution, only to be followed by another equally persuasive program, leading to a seemingly continuous series of fads and fashions.

One of the chief contributions of the present theoretical effort is to provide the policy makers with a general framework that will enable them to locate all programs in terms of which natural support groups are likely to use them and which are not, what class of exchanges is likely to be encouraged and what ignored.

For instance, if a policy maker is presented with a program to support centralized senior citizen centers that would develop recreational and social programs and to be the location for inexpensive hot meals, the policy maker who understands the framework presented in this study should immediately note that such centralized senior citizen centers do not address themselves to tasks or groups which require immediate neighborhood proximity (e.g., emergency medical, protection

of household, services which are supplied by immediate neighbors) or to tasks which require long term commitments (such as provisions of everyday household activities for chronically ill, which requires younger kin). He should spot this right away, because senior citizen centers of this type tend to exclude immediate neighbors and children of older people. Having a framework to understand in what sense these are unique groups, the policy maker can immediately think of all the activities which are characterized by immediate proximity and long term commitment.

Given that the theoretical framework permits the policy maker to diagnose what is included and what is excluded, it permits yet another policy evaluation: What is the consequence of supporting the suggested program over potential alternatives? In the illustration above, what is the consequence of supporting programs for senior citizen centers versus support for programs which deal with neighbors and kin? In this thought process he does not have to list the interminable possibilities of exchange, but he can classify all of them into five dimensions and their various combinations, an enormous simplification which should enable the policy makers to act rather than be paralyzed with the enormity of evaluating the endless exchanges which confront them.

This consideration of alternatives is guided and simplified by yet another proposition from the theoretical framework, and that is that primary groups tend to have different structures and therefore are unlikely to be able to provide functional substitutes for each other. One of the key questions facing policy makers who deal with

natural support systems is the extent to which one can use neighbors, kin and friends interchangeably to take care of chronically sick people. Our framework suggests it is in principle not possible for the bulk of the population.

The astute policy maker is confronted with the fact that those over 65 are not a homogeneous group. They range from healthy married couples to sick single people in the community to institutionalized sick. It raises the questions, do the natural support systems function the same way for all groups, and do all groups have the same importance at each stage? The theoretical framework provided in this paper points out that their key problem is the breakdown of individuals and the marital dyad. Once the problem is stated in this fashion, it is possible to indicate the major parameters of the tasks handled by individuals and marital dyads and to note which primary groups have matching structures and which will be lost because typical primary groups do not match. In this regard, the marital dyad is unique in combining continuous contact with long term commitment. Most of the crucial daily tasks of personal grooming and household care, such as cooking, cleaning, shopping, bathing, etc., require both. Our analysis suggests that younger kin may be the only primary group that can provide help with these services on an ongoing daily basis. That is because friends who may have long term commitments are generally age peers who are themselves too frail for such daily exertion. Neighbors who have proximity do not generally have the long term commitment to provide daily service on a non-paid basis. Given that the older persons are not full-time in the labor force, they can generally move close enough

to kin to make kin help sufficient for all but the most seriously disabled. Thus the theoretical framework suggested herein says kin will play an increasingly important role for aged who are disabled (e.g., sick, single, and poor). However, this same analysis would suggest that at the stage where older people are married and robust, sociability is a major element in retiree lives, and given their unique pattern of daily time, age, point on the life cycle, there would be enormous virtue in living in age honogeneous communities, thus in retirement communities.

Put somewhat differently, the structure (i.e., long term commitment and age heterogeneity) of the kin which makes them crucial in the second stage of disabled, makes them inappropriate in the first stage (i.e., long or short term commitment and honogeneity). This theoretical statement provides the policy maker with clear cut criteria for evaluating programs designed to deal with these two stages.

For instance, many recently retired seek out retirement communities, drawn by the obvious advantages such as recreational facilities, a community of others with common time patterns and interests, and convenient shopping and medical facilities. They do not think about the negative consequences of these facilities if they should get seriously ill and need daily help in personal grooming or housekeeping.

For the policy maker, it is necessary to somehow inform such people that retirement villages most suited for them at this stage may be extremely incompatible with housing necessary for the second and third stages of aging. Thus, if people desire to make such a move, they must be aware that it may be necessary for them to move again if they

are disabled, or move to a retirement community which is close to children or younger kin, or, alternatively, to seek a solution which allows one to handle all three stages. We should like to explore these issues and show in what sense the theoretical framework provides guidelines for evaluation.

Some have recognized that there are stages of disability in aging and have suggested housing solutions. One such solution is a retirement community which has separate dwellings for older persons who are robust, a hotel-like arrangement with maid service for those who are too ill to handle everyday tasks but who could still be maintained in the community, and a nursing home arrangement for those who were too ill to live by themselves. The theory suggests such a solution will fail at the second and third stages. It will fail at the second stage because it assumes that everyday care can be handled by paid staff (hotel service) and neighbors, because retirement communities tend to rule out the proximity of children. If our above analysis is right, paid staff cannot be relied on to handle the idiosyncratic or non-uniform aspects of personal grooming and household function. The best they can do is to handle them on a routinized basis. Given the economic recruitment, there is also a good chance that paid staff will exploit older persons. As already indicated, only younger kin can supply the non-uniform services necessitated by the seriously disabled living in the community.

Given this analysis, policy makers should not encourage the development of retirement communities with this three tier housing unless they can find some means to locate them near children. Surely

such retirement communities which involve moving older people to cities far away from children should not be encouraged if our theoretical framework is correct. Given differential housing needs at each stage, the policy can be one of pointing out that older individuals must choose which stage of their life they would like to optimize. For those with low income, such a choice may be necessary unless the government provides subsidies for moving the ill to their children. In this regard, in the United States local community laws requiring older people to be residents to qualify for medicaid would operate in precisely the opposite direction.

Yet another policy possibility -- government housing programs for the poor elderly which stress moderate size housing projects for the aged in areas close to regular housing -- might enable older persons to choose between the first and second stage housing locations with minimum disruptions. Government programs which provide for very small housing developments for older persons scattered throughout the city, or provide subsidies for people to fix up housing quarters for older persons in their own homes, would provide optimal housing quarters for older persons in the second stage of disability, i.e., near children. If this were combined with large scale housing for the aged in the first stage, then the policy would be one of developing specialized housing for each stage. The theoretical orientation developed here provides the policy maker with a basis for justifying two types of housing plus some programs for moving people from one to another with increasing illness.

The framework developed here also provides criteria for evaluating the location and size of nursing home structures. The theoretical framework points out in principle each primary group has an important and different function. Its ability to help members is limited by technical knowledge and its limited physical resources. It suggests for people who are extremely ill, no primary group can maintain them in the community without destroying the original goals of its members. Thus, in principle, it suggests ruling out solutions which say we can do without nursing homes. However, this same theory suggests that nursing homes can only provide routinized care. Therefore, all nursing homes must be supplemented by community primary groups with long term commitments (i.e., younger kin). To make nursing homes as close as possible to kin so as to make kin supervision and supplementation possible, homes should be scattered throughout residential areas; that generally means they should be as small as possible. In short, the framework provides policy makers with one basis for evaluating the location and size of nursing homes. More generally, it provides policy makers with a basis for evaluating housing policy for the aged. Some might argue that volunteers can be used in nursing homes to help the aged. The theoretical framework suggests volunteers could only handle tasks which do not require long term commitment, e.g., help people write letters, chauffeur them to recreational activities. However, volunteers cannot be expected to remove older persons from a home and find a new one if staff abuse is noticed; volunteers cannot be expected to keep track of possessions to see if any of them have been lost, and purchase new ones if they have been, etc. Our theory would sensitize the policy

maker to the fact that volunteers cannot substitute for kin. Both do different things.

So far we have spoken only of non-paid relations. One major question is whether one could pay neighbors or friends to take care of the ill older person. In that case the older person would not have to move as they go from robust health to chronic illness. It is also the case that many kin do not have the time and energy to provide aid to the older person who is sick. They would require financial help to do so. Still others would say one should pay neighbors and kin in order to delay if not eliminate institutionalization altogether.

Our analysis would suggest that there are some major problems in trying to use paid individuals to handle everyday household tasks, such as the inability to supervise them and the inability of strangers to know the idiosyncratic tastes of the ill person. This is especially the case of the elderly who are sick or senile. If an elderly, somewhat disturbed older person is missing some small household item, is it because she has misplaced it or because it was stolen? If the elderly older person accuses a housekeeper of being a poor cook, is it because the housekeeper does not have a sense of the other person's food tastes, has not made enough effort, or the older person is just feeling malicious? It is very difficult for an outsider to say.

In general, if one is going to have a paid person handling household tasks, it is generally necessary that they be closely supervised or have some internalized commitment, that is, operate on a non-paid basis as well. In the case of elderly infirm people, the issue of close supervision is problematical. The idea of paying a primary

group member to do the housekeeping has the virtue of insuring that the paid helper has an internalized motive.

It has several problems. First, it assumes that the relative has sufficient time, and will not destroy their own primary group network. More generally, the sicker the older person, the more full time the helper must be, and that raises the question, who will take care of the helper's family?

A variation on this problem is that the helper might hold a job which pays more and is more intellectually and socially exciting than that of being a housekeeper. This becomes a problem the higher in the social economic order the older person is. Society cannot afford to pay those from higher income groups a matching salary to become a homemaker.

Yet another variation is to provide money to the kin to hire an individual to be a caretaker to the older person, but that the kin should come in several times a week to supervise. This would seem like an ideal solution for those kin who come from higher economic groups and would not want to be housekeepers themselves. It assumes that the older person is not too far gone, since the kin in such cases cannot provide full time supervision. The more they could rely on some supervision by the older person, the better this program might work.

The problem of economic pay has another side which must also be addressed. The primary group members do much for each other on the basis of non-economic rewards, that is, affection and duty. If one introduces an economic incentive, will it destroy this relationship? There is good reason to believe that introducing some economic

incentives is positive for increasing social bonds between family members. Thus Anderson (1977) suggests that providing older persons with social security income actually led to closer ties with kin because it enabled the older person to contribute to the cost of services when kin aided them. However, if one is talking about paying kin to spend a considerable amount of their time with the older person, it is more like a full time job. Then it is not clear that the relationship of employer and employee might not begin to erode kinship ties.

From the government's point of view, another problem arises. So much help is now provided free of charge by kin to each other, if the government undertakes to provide funds, will it open the flood gates for requests for payments from all kin for services they provide to older people? The expectation that kin aid should be economically rewarded could grow to the point where it would eventually destroy the primary group form of exchange, not to mention bankrupt the government.

Though the above are indeed dangers that must be explored, it is very important for policy makers to recognize that where individuals cannot make use of primary group exchanges because of disability, they are as disadvantaged as if they were economically poor and could not get hold of various goods provided by formal organizations such as medical services, proper food, proper clothing, and proper shelter.

It would seem clear that forms of kinship aid which clearly involved formal organizations might be subsidized by the government with the least likelihood of destroying the kinship system. For instance, if our social structure demands that kin live at some distance from each other while at the same time suggesting that kin are

important to the older person, mechanisms of communication over distances are central. Government subsidies for travel and telephone expenses must be considered a valid cost for those individuals with little income. Such programs might be minimally interfering with primary groups while permitting them to operate much more effectively as primary groups. The housing programs suggested above also fall into this category of help which is least likely to disrupt primary group ties.

In addition, the government which is currently supplying general funds to older persons must recognize that certain forms of services and gifts from kin and friends should not be considered income which in turn would cause the government to withdraw its funds. Thus older persons in the United States getting medicaid payments for home care should not be penalized if kin decide they want to provide some extras not normally given by the formal organizations, such as special pillows, special pictures on the wall, a T.V. set, or taking people out to special meals, etc., etc. These gifts and services involve non-uniform events, which normally will not be provided by paid persons. They are the normal exchanges of kinship and should not be discouraged by financial penalties. Put another way, the wealthy are not only better off because they have more money and can purchase organizational resources, but at the same time they also have kinship and primary group supports. If one argues that a condition for the government providing income subsidies is to cut off kinship forms of aid, then one is basically trading off uniform help for non-uniform help and leaving the poor in a disadvantaged state, even if the income

subsidy enabled them to match those not receiving subsidies. The latter would still have non-uniform help from kin. Our theory provides policy makers with a basis for maintaining both kin and governmental subsidies.

With regard to providing direct primary group services, it would be our theoretical argument that the government must differentiate between those which we have labeled normal and those which require one primary group more or less replacing another, that is, kin, friends, and neighbors substituting for the marital dyad when it can no longer function. It would seem that the optimal situation in such cases is to hire someone who closely matches the older person in primary group attributes because the nature of the tasks to be handled are highly non-uniform. At the same time, supervision should be maintained by a primary group member. Where the level of care is so high that only a primary group member can undertake it on a full time job basis, then we would feel that the conflict between primary group and economic tensions becomes so great as to raise serious questions about the survival of primary group ties. In addition, such circumstances raise serious questions as to the helper's ownprimary group and how they might survive such intense loss of a key member. It is at this point that it is probably wiser to move in the direction of the use of large scale formal organizations with primary group members coordinating, that is, keeping an eye on the staff and providing non-uniform supplements to the formal organization's uniform types of services.

What we have tried to do in this section is show how a theoretical orientation can provide a basis for the policy maker to evaluate

key policies in the field of aging. It would be naive to assume that such a framework would be decisive. The fact of the matter is that the policy maker is confronted with already-existing contending groups with vested interests. These interests may be more powerful than any theoretical statement as to what is most effective. Nevertheless, there are times when the policy maker has some option, such as when contending groups cancel each other out, where the area has not as yet attracted contending groups, or where the policy maker has overwhelming political strength. It is for such circumstances the above analysis might be used as a basis for making policy judgment.

Many social scientists might well question the use of theories which are not as yet completely verified as a basis for making policy. It is unfortunately the case that policy makers must make decisions before all the facts are in. Their options are often limited to selecting between several views, none of which has been verified. The obligation of the social scientist is to point up the limits of verification and with the qualification to present the theories which they think are most promising. It is in that spirit we present our formulation for the consideration of policy makers. For fellow social scientists, we are suggesting a theory for dealing with network exchange amongst primary groups. We would hope that they would be sufficiently intrigued to see if it can indeed be documented by further research.

FOOTNOTES

[1]It is also the case that some add dimensions that we are not considering or omit some we are considering, but for the most part, neither the alternative formulations or the number of dimensions will alter the logic of our presentation. At best, it will add some complexity we have not considered or eliminate some we have considered.

[2]We will not try to differentiate between various configurations of large sized groups such as those suggested by network theorists (Bott, 1955; Mitchell, 1973).

[3]If three siblings are in the labor force and one is a professor in economics, the other an aeronautical engineer, and the third is an assembly line worker in an auto factory, then the demands of labor might be such that one will end up at one end of the country, the other at the opposite end, and the third in the middle. Furthermore, one might be extremely wealthy, one moderately wealthy, and the third not wealthy, and, as a result, they may live in very different types of housing and neighborhoods, even if they were in the same city.

[4]The term friend has been used to cover several different relations. In some cases they refer to life-long friends, in some cases to short term occupational friends, and insome cases to acquaintances, that is, people one knows slightly who may be long or short term. Structurally, the long term friends would have to share with kinship systems the ability to communicate over distance, while the short term friends must share with neighbors the mechanism of quick

socialization. It would be our hypothesis that these two types of friends do very different things.

The acquaintances open up yet another world. This is a world that has been highlighted by network theorist Mitchell (1973) and people such as Granovetter (1974). Acquaintances are generally characterized as representing extremely large size groups and by the fact that they may not have one of the central features of a primary group, that is, the non-instrumental notion that the group survival is good per se.

We will not systematically consider the different configurations of acquaintances in this paper. In general, they handle different types of tasks than the groups we are considering. They follow the same principles of matching structures of the group with structures of the task. It is our view that the analysis of acquaintances or "networks" will not contradict what we are suggesting but it will add to the complexity and completeness of our explanations.

Finally, it should be noted that the term friend is sometimes used for people who are fictive kin. A person who raises the child of a friend or a distant relative may treat and relate to that child as a kin. In terms of our analysis, the relation has the dimension of kin and not friend.

[5]They do not deal with sequences where a primary support group skips the second stage and then provides at the third stage.

[6]For complete description of sample, see Litwak et al., 198).

[7]Sussman (1980) points out in a study of two cities that an overwhelming majority are willing to include older parents in their household, though this same majority would prefer an alternative of separate households. It is also not clear the extent as to which such acceptance of older people is based on the assumption it will be temporary or one is dealing with a single parent who can provide household help. Though he wishes to stress the astonishing acceptance of joint living patterns, we read his data to say that typical families neither prefer nor have such a solution.

[8]For instance, daily grooming, feeding, and housekeeping functions when considered as a package require continuous daily contact. To make such contact daily on a non-paid basis requires an enormous amount of time and energy and therefore a long term commitment. When we say the function is lost, what we mean is that where the older person is disabled so that they cannot do such everyday tasks, they will appear disheveled, in dirty and torn clothes, or remain in night clothes all day, and their apartment will be filthy. Eventually this will lead to shorter life spans.

[9]We are not considering the logical possibilities of institution picking up lost functions which they do or any reversals from nursing home to community. It is our intention to analyze those patterns at a later date. Such an analysis will not basically alter the points we are making here.

[10]The use of regressions must be treated with caution because we do have a dichotomous dependent variable. We use it more as description of the curve than to explain the amount of variance. Its usefulness becomes more apparent when we examine these curves under multiple controls.

[11]We only interviewed people in nursing homes who were able to talk. A substantial majority were either too senile or too sick to be interviewed. Most of the people in the congregate living facilities could be interviewed. Though we selected the homes in a random fashion we were not able in most cases to select the residents of these institutions randomly. We took 80 institutions (that is, 40 in New York and 40 in Florida). These were selected at random from a master list supplied by the state licensing agencies and provider of medicaid funds. Based on the size of the institution we had a quota of older residents who should be interviewed. The administrator or supervisor of nursing listed all people who could be interviewed. In most skilled nursing homes there were so few able to talk that we had to take all of them. In all these cases we had to rely on the judgements of the nursing home staff. In the case of the congregate living facilities, announcements were made by the staff and we were only permitted to approach those who volunteered.

It is not clear how kin relates to older people who could not talk or how much bias was introduced by our inability to select the sample on a more random basis.

[12]Where the individuals are ill, there is sometimes a negative effect on neighbors and friends exchanges. There are two reasons: First, neighbors are asked to perform tasks for ill people which go beyond their limited time commitment, so they respond by avoiding contact. Second, the sick person's inability to continue contact causes the relation to atrophy. We will not discuss this phenomenon, though some of our data support this possible negative effect.

[13]There are three reasons for a continuum. First, the dimensions of group structure are not dichotomous. This is apparent for dimensions such as "face to face continuous contact" where one can differentiate between hourly continuous contact, daily, weekly, monthly, and yearly. It is also true but not as obvious about affection where one can speak about the deep love of spouse or parents, affection of friends, friendliness to acquaintance, politeness to stranger, etc.

In short, all dimensions of group structure and task structure are on a continuum (Litwak and Meyer, 1978). The other two reasons for a continuum have to do with imperfect socialization and measure-

ment error. First, socialization is never perfect (Parsons, 1951) that is, people do not always conform to roles. Therefore, there are always staff and residents who develop primary group ties, etc. The second type of error has to do with item ambiguity (Dono et al., 1979). Thus a question which asked who has checked on you daily without specifying whether it is visual or by telephone will be answered by neighbor or kin, depending which meaning the respondent gives to the question. It is the fact of measurement error of the latter two types which often accounts for two or more groups overlapping in exchanges.

[14]These are precisely the complaints which have arisen in the New York City home care programs. It has caused the city to seek an alternative method for delivery of services.

TABLE 1

Types of Shifts from Marital Households to Larger Community Primary Groups to Institutions

	STAGES OF HEALTH			NAME OF SEQUENCE
	FIRST STAGE: Married with Minor Ailments	SECOND STAGE: Single with Major Ailments	THIRD STAGE: Institution-alized, Single, Major Ailments	
1.	Task handled by individual or spouse	Task handled by supporting primary group, e.g., kin, friend or neighbor	Task continues to be handled by primary group and not institution	Primary Group Expansion
2.	Task handled by individual or spouse	Task handled by supporting primary group, e.g., kin, friend or neighbor	Task handled by institution	Partial Primary Group Expansion
3.	Task handled by supporting primary group, e.g., kin, friend, neighbor	Task continues to be handled by support group	Task continues to be handled by support group	Primary Group Continuation
4.	Task handled by supporting primary group, e.g., kin, friend, neighbor	Task continues to be handled by support group	Task handled by institution	Primary Group Decline
5.	Task handled by individual or spouse	Task not handled by support primary group or institu-tions	Task not handled by institution or primary group	Lost Function

TABLE 2

Sequencing of Primary Group Structures with Stages of Health
Starting with Normal Functions of the Marital Household

DIMENSIONS OF TASK				PRIMARY GROUPS AT EACH HEALTH STAGE			NAME OF SEQUENCE
Initial Size Large	Same generation required	Continuous Proximity Required	Long Term Commitment Required	FIRST STAGE Marital Household Intact	SECOND STAGE Marital Household Broken & Disabled	THIRD STAGE Marital Household Broken & Disabled, Institution Takes Over	
WHERE THE INSTITUTIONS CAN HANDLE THE THIRD STAGE							
No	No	No	Yes	Marital	Kin	Institution	*Partial Kin Expansion
No	Yes	No	Yes	Marital	Friend	Institution	Partial Kin Exp.
No	No	Yes	No	Marital	Neigh.Het.	Institution	Partial Neighbor Exp.
No	Yes	Yes	No	Marital	Neigh.Hom.	Institution	Partial Neighbor Exp.
No	No	No	No	Marital	Acquaint.Het.	Institution	Partial Acquaint.Exp.
No	Yes	No	No	Marital	Acquaint.Hom.	Institution	Partial Acquaint.Exp.
WHERE PRIMARY GROUPS HANDLE THE THIRD STAGE							
No	No	No	Yes	Marital	Kin	Kin	*Full Kin Expansion
No	Yes	No	Yes	Marital	Friend	Friend	Full Friend Exp.
No	No	Yes	No	Marital	Neigh.Het.	Neigh.Het.	Full Neighbor Exp.
No	Yes	Yes	No	Marital	Neigh.Hom.	Neigh.Hom.	Full Neighbor Exp.
No	No	No	No	Marital	Acquaint.Het.	Acquaint.Het.	Full Acquaint. Exp.
No	Yes	No	No	Marital	Acquaint.Hom.	Acquaint.Hom.	Full Acquaint. Exp.
SOME ATYPICAL SEQUENCES - LOST FUNCTIONS							
No	Yes	Yes	Yes	Marital	Joint Household Friends	Joint Household with Friend	Atypical-lost function*
No	No	Yes	Yes	Marital	Joint Household with Children	Joint Household* with adult child	Atypical-lost function

*We have empirical data for these patterns.

Some Illustrations

Partial Kin Expansion: help in household maintenance, like putting up pictures, curtain rods, etc.
Partial Friend Expansion: planning vacation trips or recreational activities together which used to be done with spouse.
Partial Neighborhood Expansion: emergency first aid or calling the doctor in an emergency.
Partial Acquaintanceship Expansion: arranging for ad hoc occasional chauffering or purchases.
Full Kin Expansion: help in payment of monthly bills like rent, telephone, etc. Help in storage.
Full Acquaintanceship Expansion: help in writing letters to relatives.
Atypical Exchanges--Generally Lost Functions: daily grooming, dressing, cooking, clothing, housekeeping.

TABLE 3

Table of Unstandardized Regression Coefficients and Constants for Kinship Expansion[a]

	Constant (Healthy, Married)	Coefficient b_1 (Sick and Single)	Coefficient b_2 (Sick and institutionalized)	R_2
PARTIAL KINSHIP EXPANSION				
Kin provide small home repairs	.19	.27*	-.09*	.10
Kin provide daily housekeeping	.14	.20*	-.07	.07
FULL KINSHIP EXPANSION				
Kin keep track of bills, social security checks, bank accounts	.07	.39	.47	.22
Kin help in laundry, cleaning, and storage	.13	.22	.31	.09
KIN DECLINE				
Check daily to see if all right	.47	.16*	-.22	.07
Kin would help if bedridden for 2 or 3 weeks	.35	.18	-.24	.10
KINSHIP CONTINUATION				
Kin take out for dinner or brings food	.45	.18*	.08	.02
Kin bring small household gifts	,42	.09*	.04	.01
Kin help keep in touch	,47	.06	.14	.01
Talks to kin when feeling low and they cheer up	.72	.12*	.03	.02

a/ Because slight differences in population base the coefficient in the regression do not precisely match the percentages in their respective figures.

TABLE 4

Primary Group Decline and Continuation

Sequencing of Primary Group Structures with Stages of Health Starting with Normal Functions of Larger Primary Groups (e.g., Kin, Neighbors, etc.)

DIMENSIONS OF TASK				PRIMARY GROUPS AT EACH HEALTH STAGE			NAME OF SEQUENCE
Initial Size Large	Same generation required	Continuous Proximity Required	Long Term Commitment Required	FIRST STAGE Marital Household Intact	SECOND STAGE Marital Household Broken & Disabled	THIRD STAGE Marital Household Broken & Disabled, Institution Takes Over	
WHERE INSTITUTIONS HANDLE THIRD STAGE							
Yes	No	No	Yes	Kin	Kin	Institution	*Kin Decline
Yes	Yes	No	Yes	Friend	Friend	Institution	Friend Decline
Yes	No	Yes	No	Neigh.Het.	Neigh.Het.	Institution	*Neighborhood
Yes	Yes	Yes	No	Neigh.Hom.	Neigh.Hom.	Institution	*Neighborhood
Yes	No	No	No	Acquaint.Het.	Acquaint.Het.	Institution	Acquaintance
Yes	Yes	No	No	Acquaint.Hom	Acquaint.Hom.	Institution	Acquaintance
WHERE PRIMARY GROUPS HANDLE THIRD STAGE							
Yes	No	No	Yes	Kin	Kin	Kin	*Kin Continuation
Yes	Yes	No	Yes	Friend	Friend	Friend	Friend Cont'n
Yes	No	Yes	No	Neigh.Het.	Neigh.Het.	Neigh.Het.	Neigh. Cont'n
Yes	Yes	Yes	No	Neigh.Hom.	Neigh.Hom.	Neigh.Hom.	Neigh. Cont'n
Yes	No	No	No	Acquaintance	Acquaintance	Acquaintance	*Acquaint. Cont'n
Yes	Yes	No	No	Acquaintance	Acquaintaince	Acquaintance	Acquaint. Cont'n
SOME ATYPICAL SEQUENCES - LOST FUNCTIONS							
Yes	Yes	Yes	Yes	Joint Household Friends	Joint Household Friends		Atypical-lost function
Yes	No	Yes	Yes	Joint Household with Children	Joint Household with Children		Atypical-lost function

*These are the sequences for which we have some empirical data.

TABLE 5

Percentage Using Staff or Paid Help by Centrality to Institutions and Stage of Health

	% Choosing Staff or Paid Help		
	First Stage (Healthy)	Second Stage Single & Disabled)	Third Stage (Institutionalized, Single, & Disabled)
Partial Expansion or Primary Group Decline--Tasks Central to Institutions			
1. Who would help if sick in bed for 2 or 3 weeks	04	01	84
2. Who checked daily to see if all right	01	02	53
3. Who would report break-in when out shopping	08	09	40
4. Who would loan small household item in emergency	01	01	30
Full Expansion or Primary Group Continuation--Tasks Not Central to Institutions			
5. Who helped with seasonal storage, laundry and cleaning	01	02	24
6. Who did you talk to when feeling low	01	01	24
7. Who helped take care of bills, bank account, etc.	02	04	10
8. Who would join in free time	00	00	08
	Population		
	(371)	(227)	(218)

TABLE 6

Percentage Using Staff and Percentage Using Major Primary Group* for Those Living in Institutions

	% Choosing Staff	% Choosing Chief Primary Group
Exchanges Central to Institutions-- Partial Expansion or Decline		
1. Who would help if sick in bed	84	12
2. Who checked daily to see if all right	53	23
3. Who would report break-in or theft	40	34
4. Who gave small household items to make place homey	30	36
Exchanges Not Central to Institutions-- Full Expansion and Continuation		
5. Who provided seasonal storage, laundry or cleaning	24	24
6. Who talked to you and made you feel better	24	75
7. Who managed monthly bills, checked social security payments, etc.	10	53
8. Who would provide free time companion	08	56
	Population	
	(219)	(219)

*Respondents could choose as many different groups as they wanted to. For all items except number 8, the chief primary group chosen was kin. For number 8, the chief primary group was fellow residents.

TABLE 7

Lost Functions in Institutional Settings--Non-Routinizable or Non-Central Functions which Require Immediate Proximity

	% Receiving Staff Help	% Receiving No Help
Exchanges which are Central and Routinizable--Organizational Exchanges		
1. "Home care" when sick in bed for 2 to 3 weeks	84	04
2. Check daily to see if all right	54	16
Lost Functions--ambiguous with regard to Centrality and Routinizability and Require Proximity		
3. Report thefts from room	40	31
4. Borrow small household items in emergency	30	25
Exchanges which are Not Routinizable and which can be handled over distance by kin or require proximity and can be handled by Institutional Primary Groups		
5. Talk to someone when feeling low and feeling better	24	16
6. Having a companion for one's free time	08	18
	Population	
	(381)*	(381)*

*This group consists of people in nursing homes and congregate living institutions.

TABLE 8

Regression Constants and Unstandardized Coefficients at Each Stage of Disability with Income in and out of Equation[a]

Exchanges Provided by the Kin	Income Controlled	Constant (Stage 1)[b]	Regression Coefficient 1 (Stage 2)	Regression Coefficient 2 (Stage 3)	R^2
PARTIAL KINSHIP EXPANSION					
Small repairs in house	No	.19	.27*	-.09*	.10
	Yes	.30	.25*	-.13*	.11
Light housekeeping	No	.14	.20*	-.07*	.07
	Yes	.19	.19*	-.08*	.08
FULL KINSHIP EXPANSION					
Keep track of bills, checks and bank	No	.07	.39*	.47*	.22
	Yes	.18	.35*	.41*	.23
Laundry, cleaning, storage	No	.13	.22*	.31*	.09
	Yes	.19	.21	.30*	.10
KIN DECLINE					
Checking daily to see if all right	No	.47	.16*	-.22*	.07
	Yes	.52	.13*	-.24*	.08
Take care of bed-ridden for 2 weeks	No	.35	.18*	-.24*	.10
	Yes	.39	.16*	-.26*	.11
KINSHIP CONTINUATION					
Take out for meal or bring in food	No	.45	.18*	.08	.02
	Yes	.51	.16*	.07	.04
Bring in small household gifts to make more homey	No	.42	.09*	.04	.01
	Yes	.43	.08	.03	.02
Help keep in touch with relatives	No	.47	.06	.14*	.01
	Yes	.51	.04	.12*	.02
Talk to when low and cheer up	No	.72	.12*	.03	.02
	Yes	.78	.10*	.01	.03

*Figure significant at .05 or better.

[a]Income was run as a dummy variable so as to include large number who did not provide income information. The constant includes those with low income. For the income coefficients, see appendix II.

[b]The stages of health were put in as dummy variables with the constant being Stage 1 (those married and healthy).

TABLE 9

Ethnic-Racial Classifications by Kinship Aid
(Community Residents)

	% Receiving Different Kinds of Aid					
	Assimilated Americans	West Europeans	Jewish	East Europeans	Hispanics	Blacks
Partial Kinship Expansion			% Chose Kin			
Who has made home repairs	31	29	18	43	42*	-
Who does light housekeeping	16	21	12	35	34*	-
Full Kinship Expansion			% Chose Kin			
Manages weekly bills, etc.	19	19	22	36	35	25
Seasonal storage, laundry	18	24	15	36	45	22
Kinship Decline			% Chose Kin			
Who checks daily to see if all right	46	42	49	67	73	64
Who takes care when sick in bed	42	41	39	50	64	55
Kinship Continuation			% Chose Kin			
Who do you talk to when low	65	61	73	78	67	74
Who helps keep in touch	43	39	42	61	56*	-
Who provides special food	50	51	40	58	62*	-
Who provides small household gifts	43	40	31	61	63*	-
Neighborhood Decline			% Chose Neighbors			
Who watches house	77	78	64	72	78	74
Who provides emergency household items	73	76	64	61	61	63
Acquaintances Continuation			% Chose Friend or Resident			
Who is a companion in free time	44	47	48	33	25	36
			Population			
	429	207	347	141	85	65

Total 1289

*These percentages combine Hispanics and Black populations. The total population is 150.

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Table 10

Constants and Unstandardized Coefficient for Regression of Stage of Health or Exchanges with Income and Ethnicity Controlled For

Exchange Provided by Kin	Income and Ethnic Controller	Constant (Stage 1 of Health	Coefficient 1 (Stage 2 of Health	Coefficient 2 (Stage 3 of Health	R^2
Partial Kin Expansion					
Small repairs in house	No Controls	.19	.27*	-.09*	.10
	Income	.30	.25*	-.13*	.11
	Ethnicity	.22	.28*	-.07	.15
	Both	.31	.25*	-.09*	.15
Light Housekeeping	No Controls	.14	.20*	-.07	.07
	Income	.19	.19*	-.08	.08
	Ethnicity	.13	.20*	-.04	.11
	Both	.15	.21*	-.04	.12
Full Kinship Expansion					
Keep track of Bills, Checks and Banks	No Controls	.07	.39*	.47*	.22
	Income	.18	.35*	.41*	.23
	Ethnicity	.05	.40*	.48*	.24
	Both	.15	.36*	.43	.24
Laundry, Cleaning, Storage	No Controls	.13	.22*	.31*	.09
	Income	.19	.21*	.30*	.10
	Ethnicity	.12	.22*	.34*	.12
	Both	.16	.22*	.34*	.12
Kin Decline					
Check daily to see if alright	No Controls	.47	.16*	-.22*	.07
	Income	.52	.13*	-.24*	.08
	Ethnicity	.44	.16*	-.20*	.12
	Both	.44	.16*	-.19*	.12
Take care of bedbound respondent for 2 or 3 weeks	No Controls	.35	.18*	-.24*	.10
	Income	.39	.16*	-.26*	.11
	Ethnicity	.33	.18*	-.23*	.12
	Both	.34	.18*	-.22*	.13

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Table 10
(continued)

Exchange provided by Kin	Income and Ethnic Controller	Constant (Stage 1 of Health)	Coefficient 1 (Stage 2 of Health)	Coefficient 2 (Stage 3 of Health)	r^2
Kinship Continuation					
Take out respondent for meals or bring food to them	No Controls	.45	.18*	.08*	.02
	Income	.51	.16*	.07	.04
	Ethnicity	.43	.19*	.11*	.05
	Both	.47	.18*	.11*	.06
Provides small household gifts which make the place homey	No Controls	.42	.09*	.04	.01
	Income	.43	.08	.03	.02
	Ethnicity	.39	.10*	.06	.05
	Both	.37	.10*	.08	.05
Help keep in touch with relatives	No Controls	.47	.06	.14*	.01
	Income	.51	.04	.12*	.02
	Ethnicity	.48	.07	.16*	.04
	Both	.50	.05	.15*	.04
Talk to when feeling low and get cheered up	No Controls	.72	.12*	.03	.02
	Income	.78	.10*	.01	.03
	Ethnicity	.69	.13*	.03	.04
	Both	.73	.11*	.02	.04

*Figures significant at .05 or better. For ethnic coefficient see appendix II.

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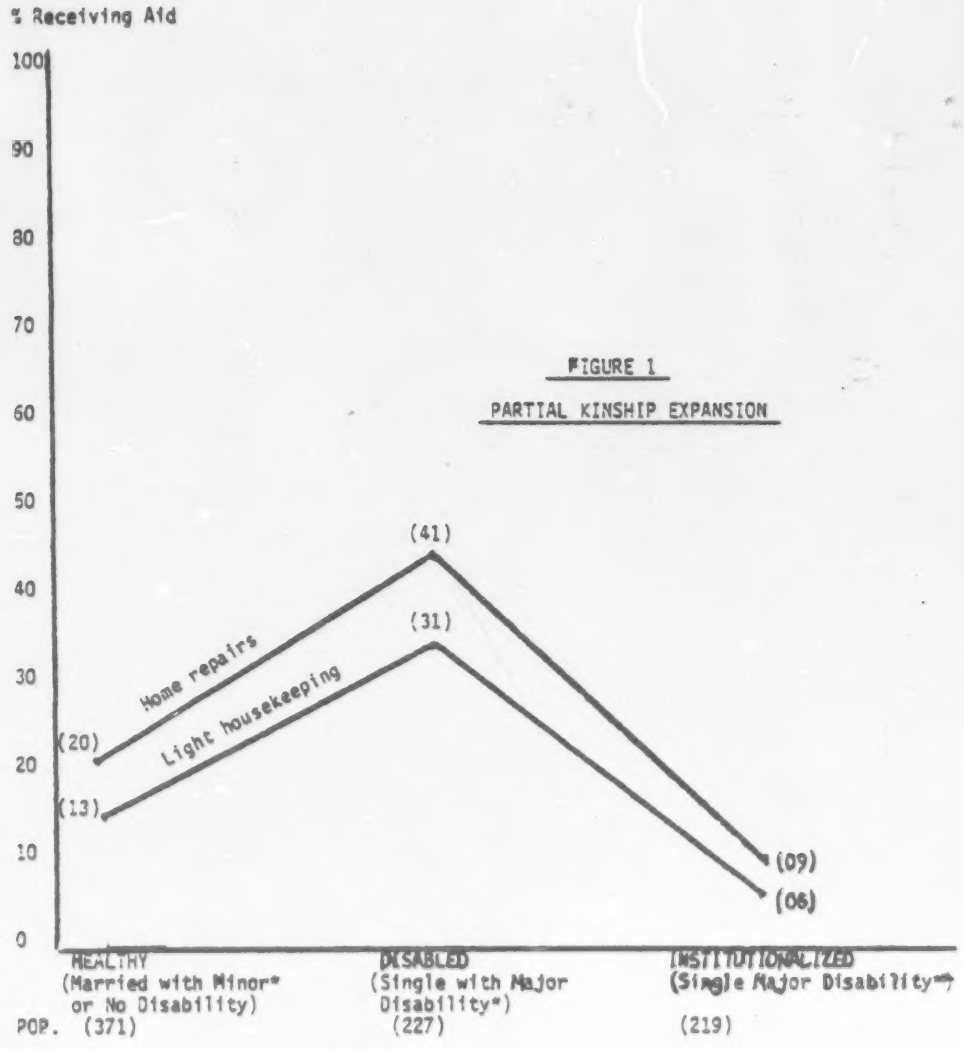

FIGURE 1

PARTIAL KINSHIP EXPANSION

* Major Disability is defined as a score on a health index which significantly increased the probability of a married individual being institutionalized. The probability was the percentage of institutionalized of the total population who had the same score on the health index. The index measured the respondents ability to handled everday household activities as well as chronic ailments, etc.

** Only people able to talk were interviewed. In many nursing homes this was less than 10% of the residents.

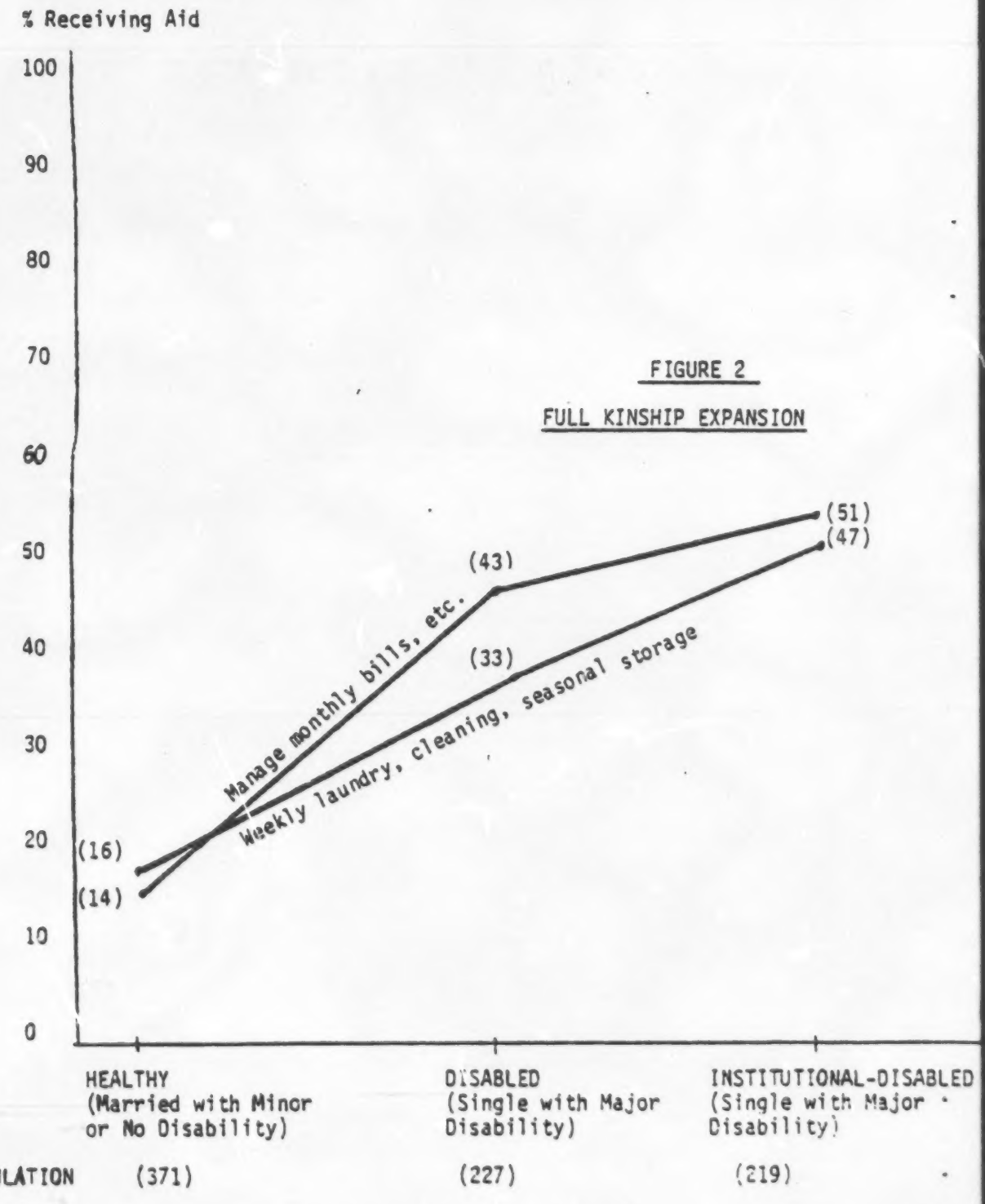

FIGURE 2

FULL KINSHIP EXPANSION

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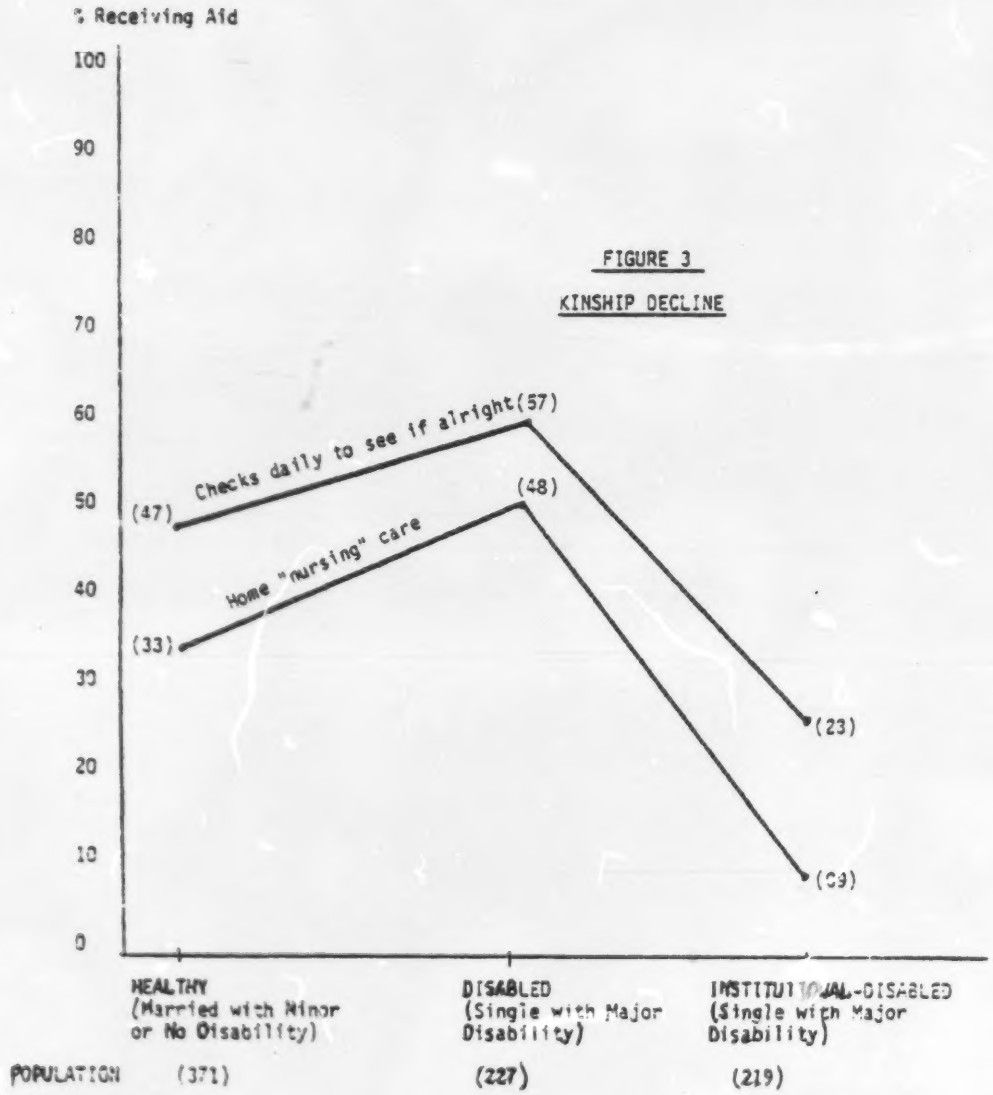

FIGURE 3

KINSHIP DECLINE

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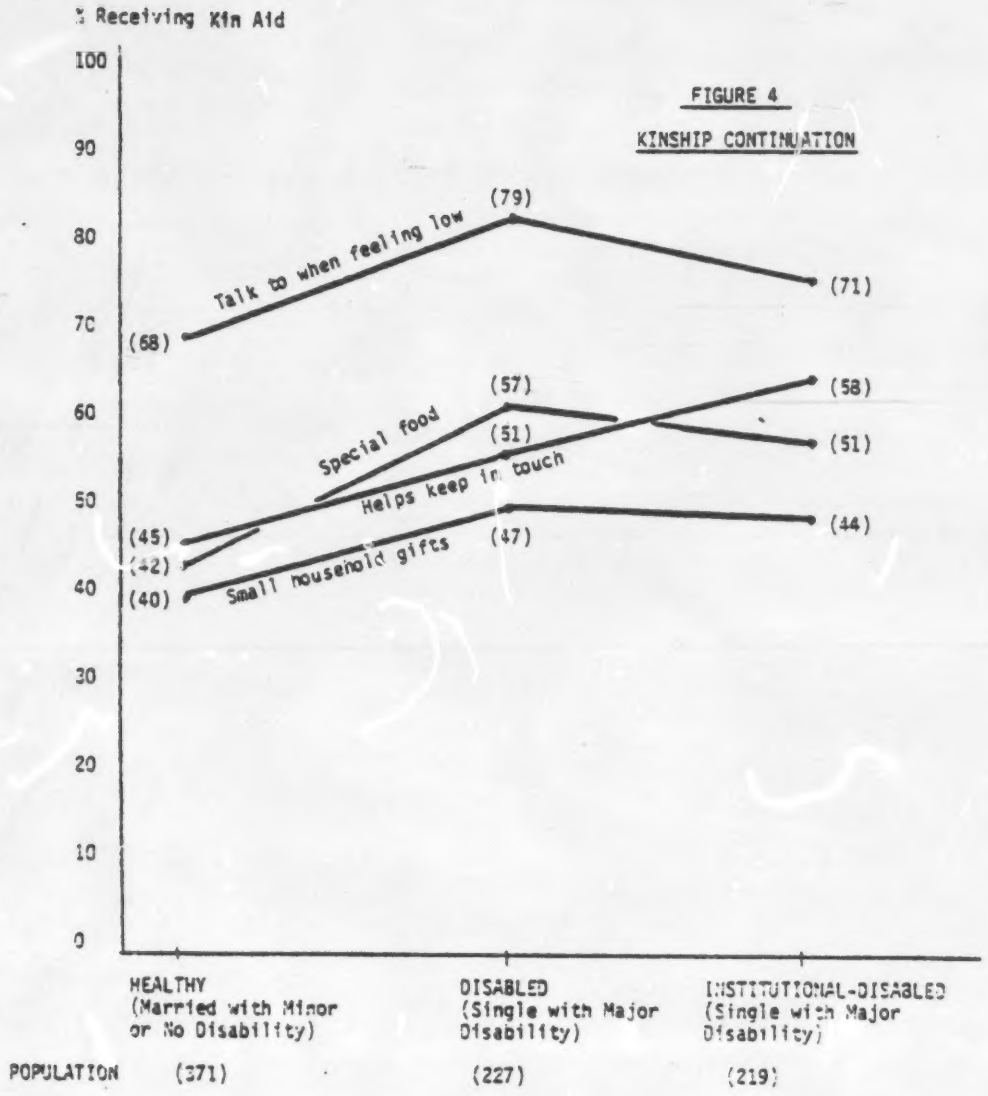

FIGURE 4

KINSHIP CONTINUATION

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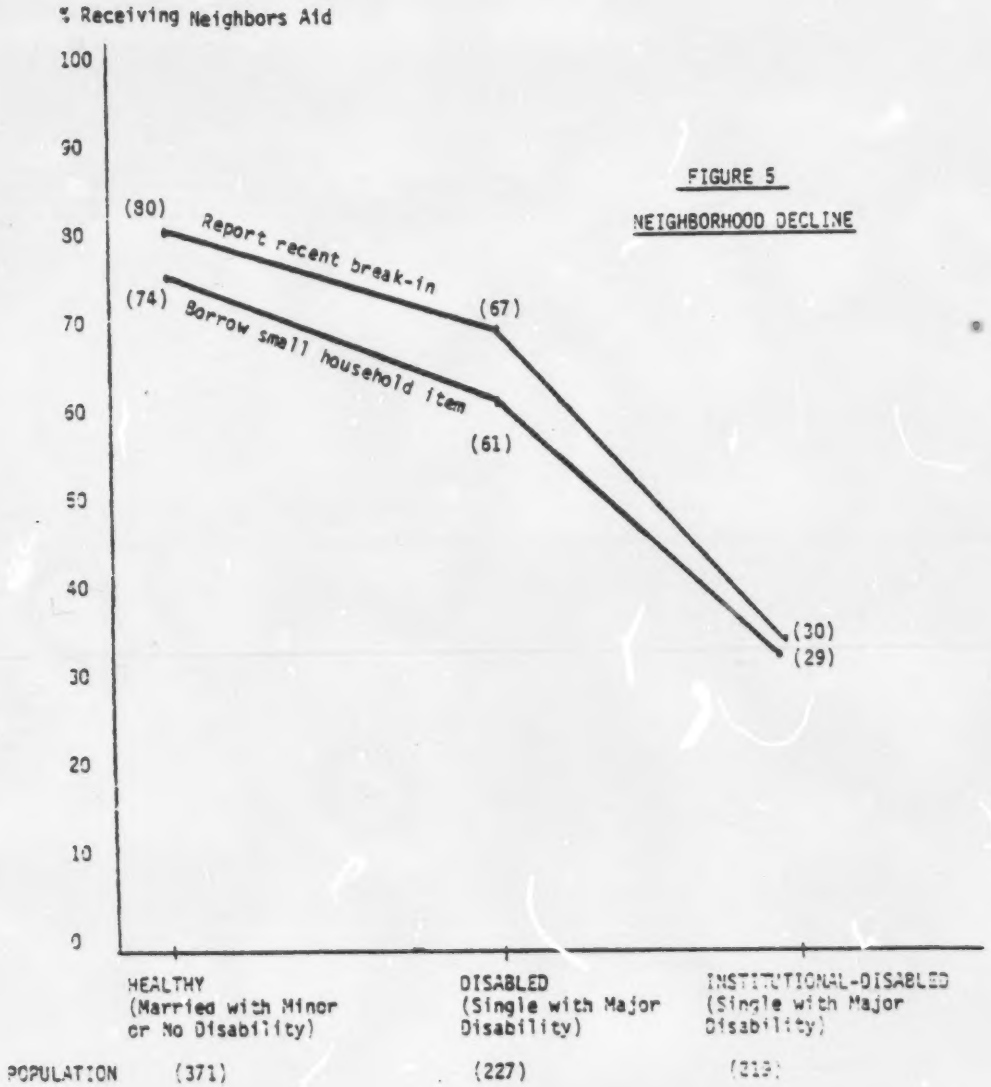

FIGURE 5

NEIGHBORHOOD DECLINE

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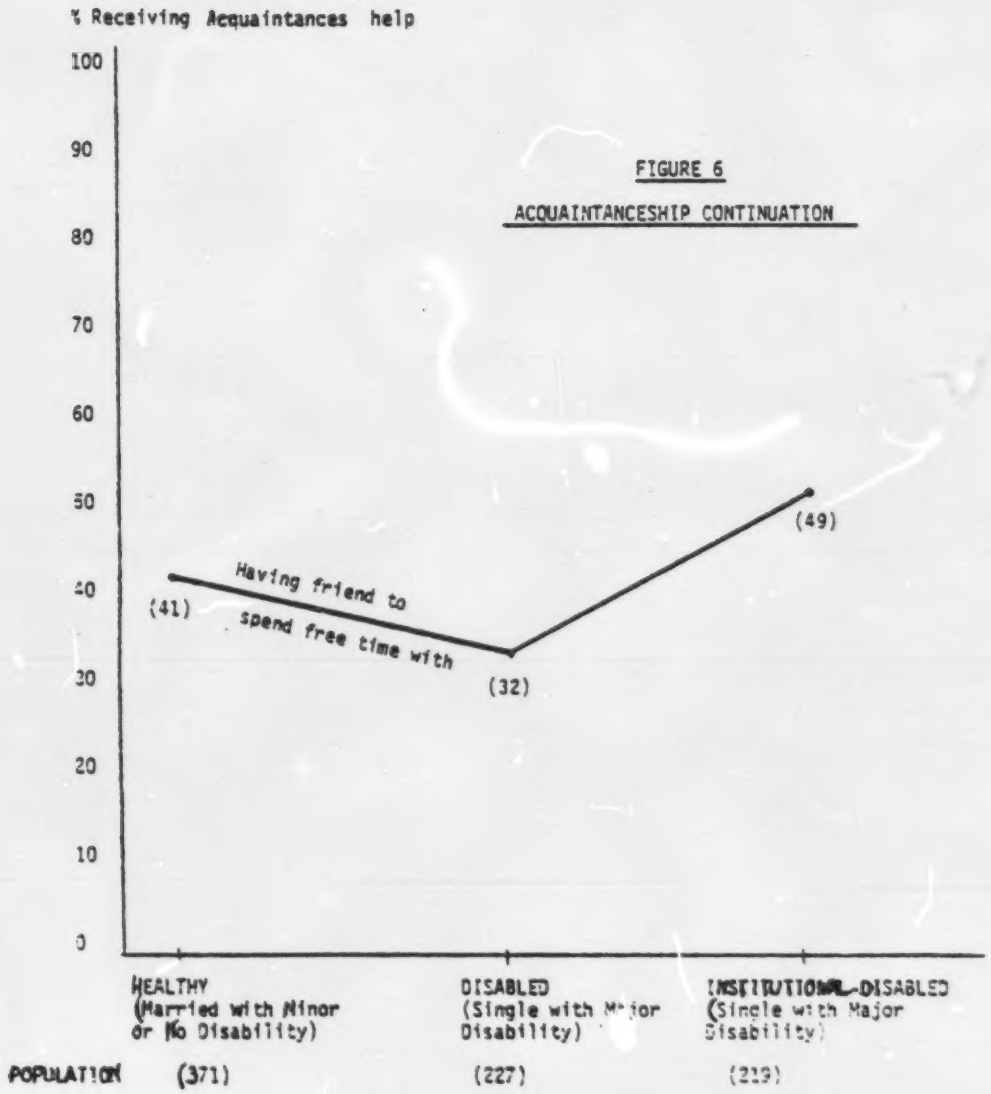

FIGURE 6

ACQUAINTANCESHIP CONTINUATION

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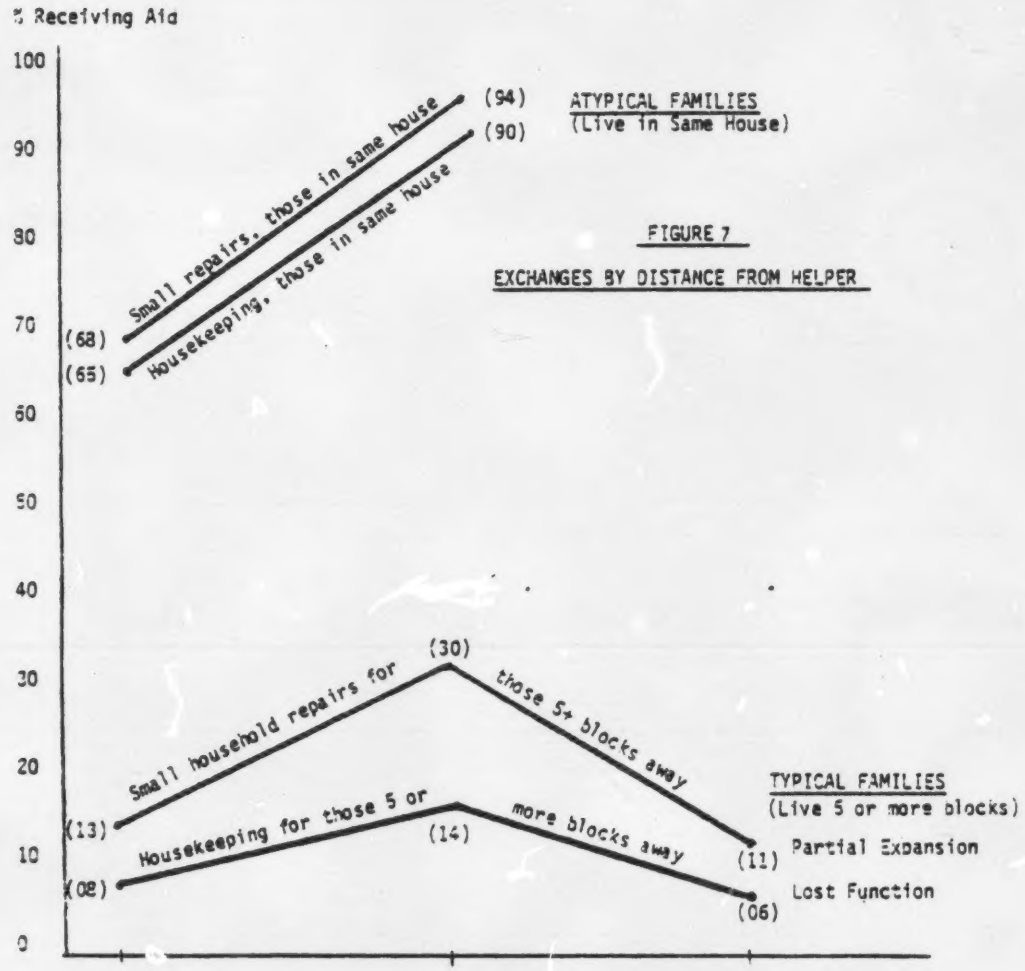

FIGURE 7

EXCHANGES BY DISTANCE FROM HELPER

POPULATION	HEALTHY (Married with Minor or No Disability)	DISABLED (Single with Major Disability)	INSTITUTIONAL-DISABLED (Single with Major Disability)
For those Living 5 or more blocks	(338)	(146)	(203)
For those Living in the same house	(40)	(51)	(01)

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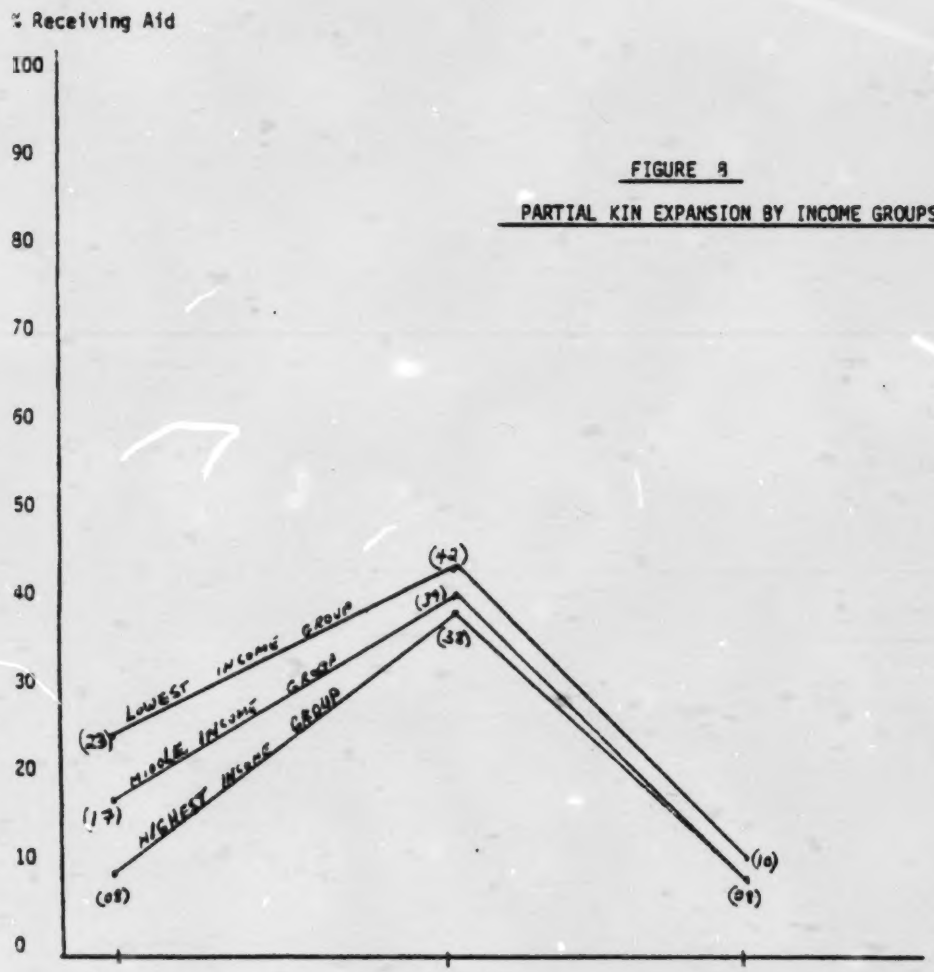
FIGURE 8

PARTIAL KIN EXPANSION BY INCOME GROUPS



INCOME	POPULATION		
Lowest	13	76	101
Middle	149	109	64
Highest	209	29	14

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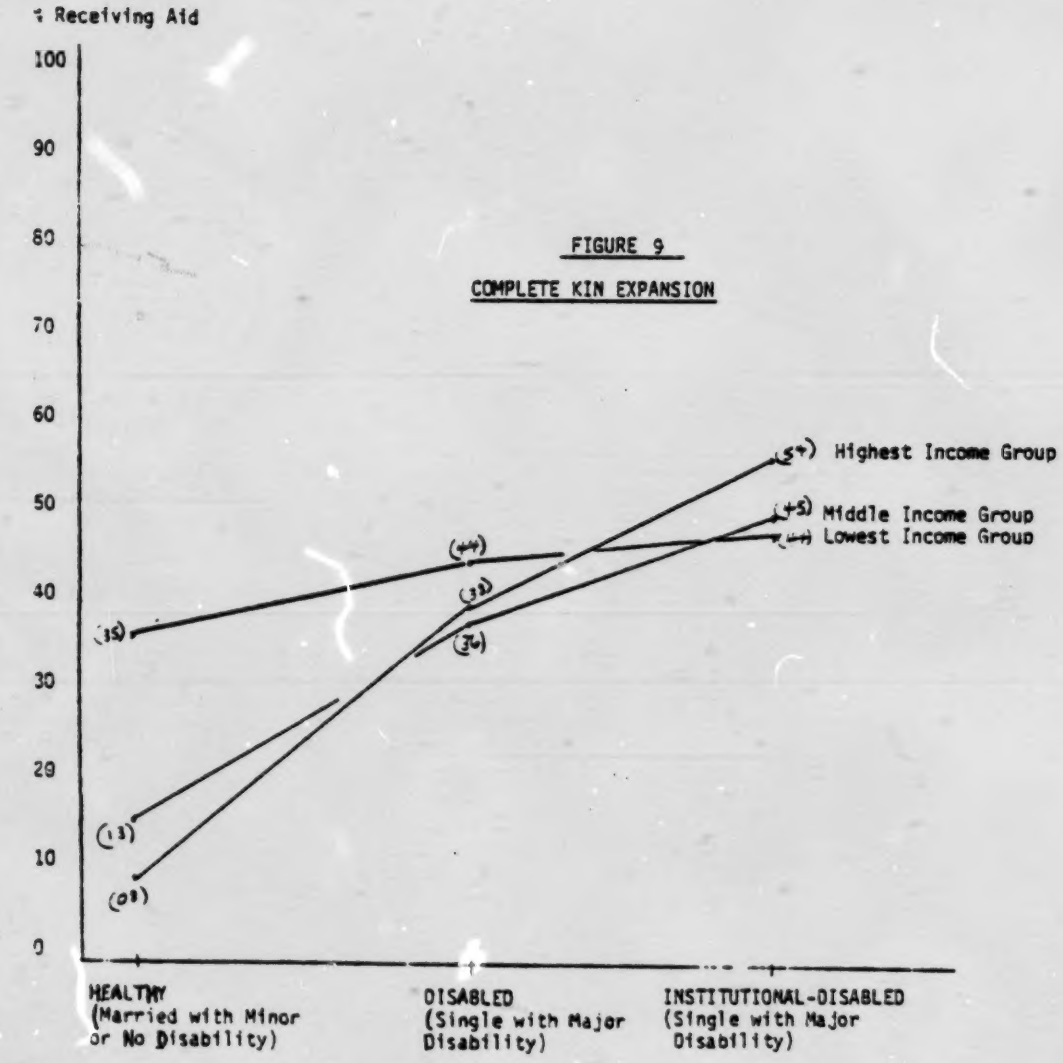

FIGURE 9

COMPLETE KIN EXPANSION

INCOME	POPULATION		
Lowest	13	76	101
Middle	149	109	64
Highest	209	29	14

BEST COPY AVAILABLE

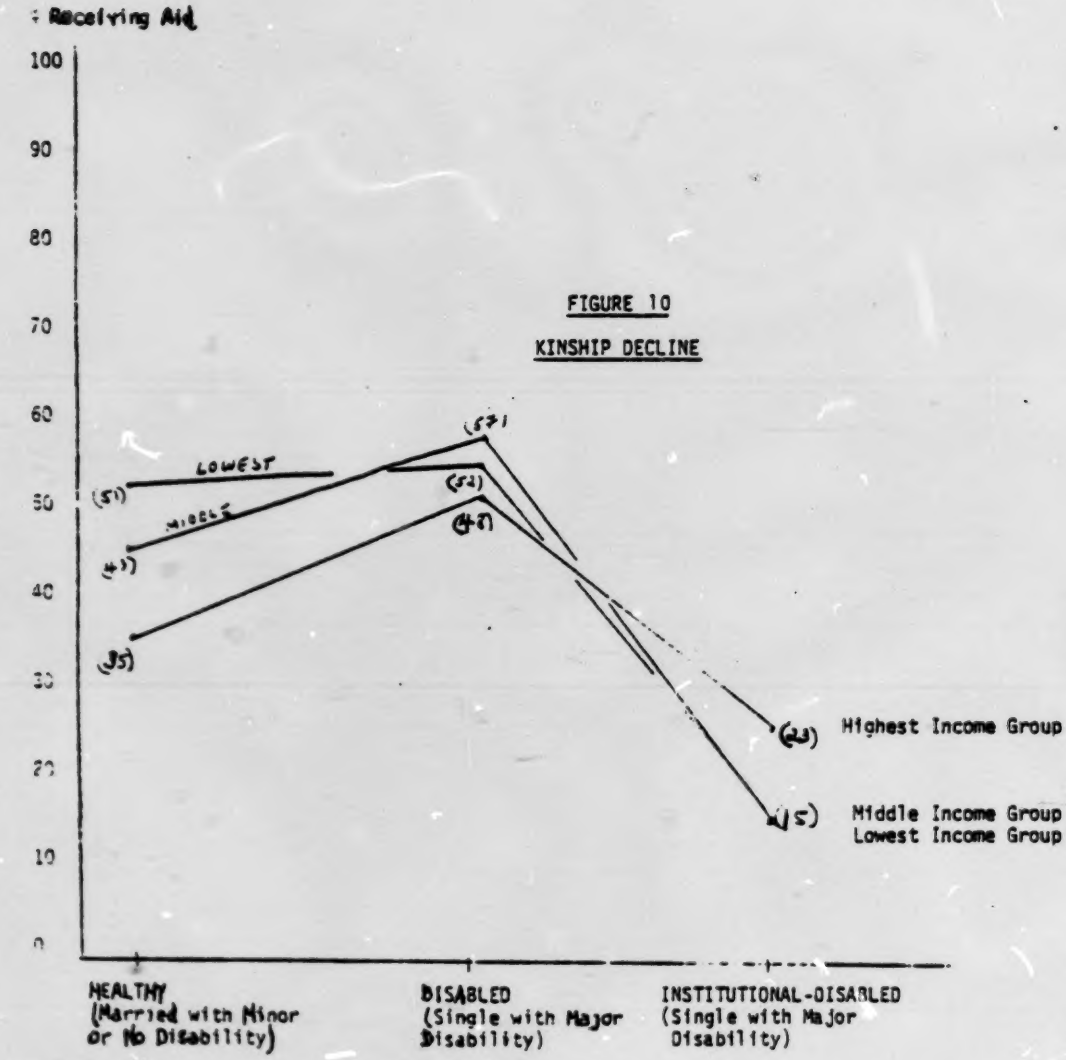

FIGURE 10

KINSHIP DECLINE

INCOME	POPULATION		
Lowest	13	76	101
Middle	149	109	64
Highest	209	29	14

BEST COPY AVAILABLE

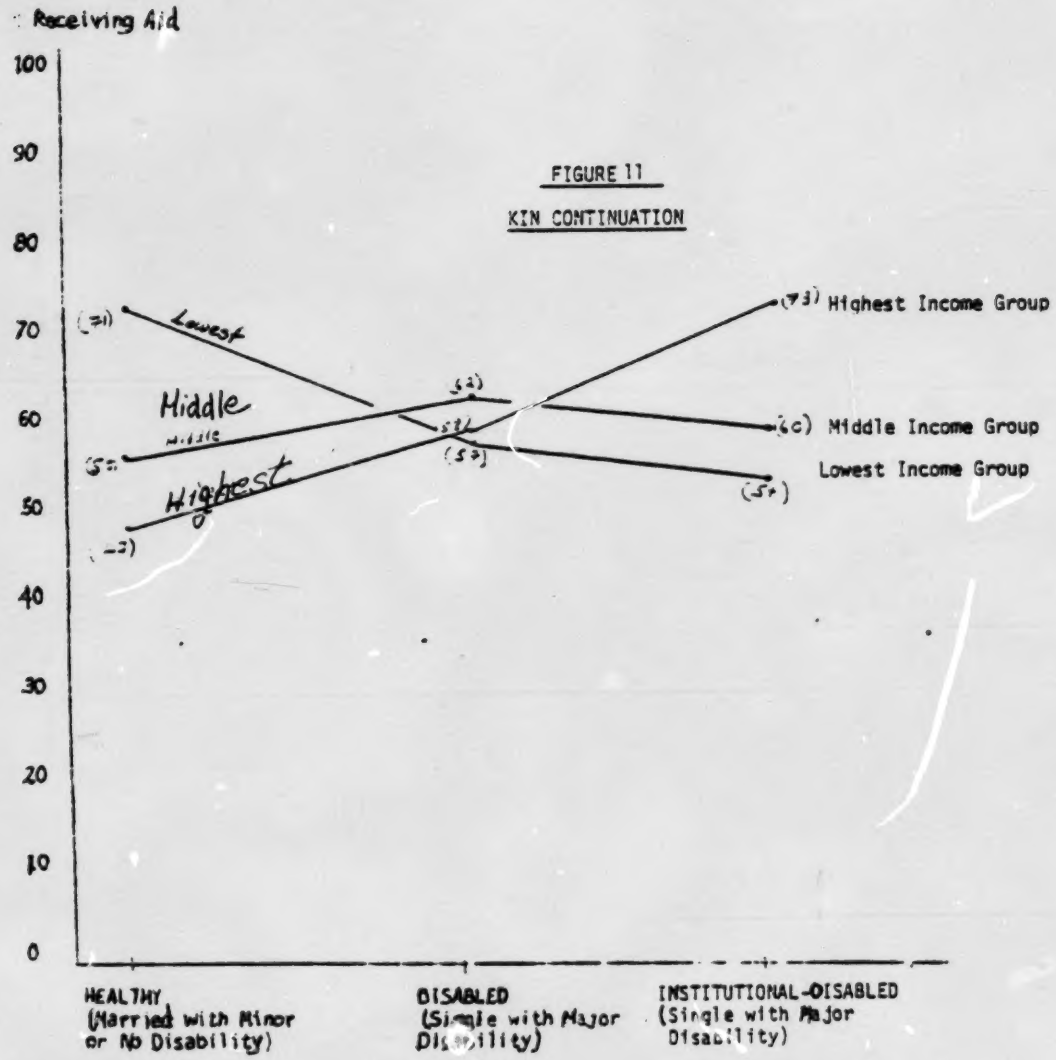

FIGURE 11

KIN CONTINUATION

INCOME	POPULATION		
Lowest	13	76	101
Middle	149	109	64
Highest	209	29	14

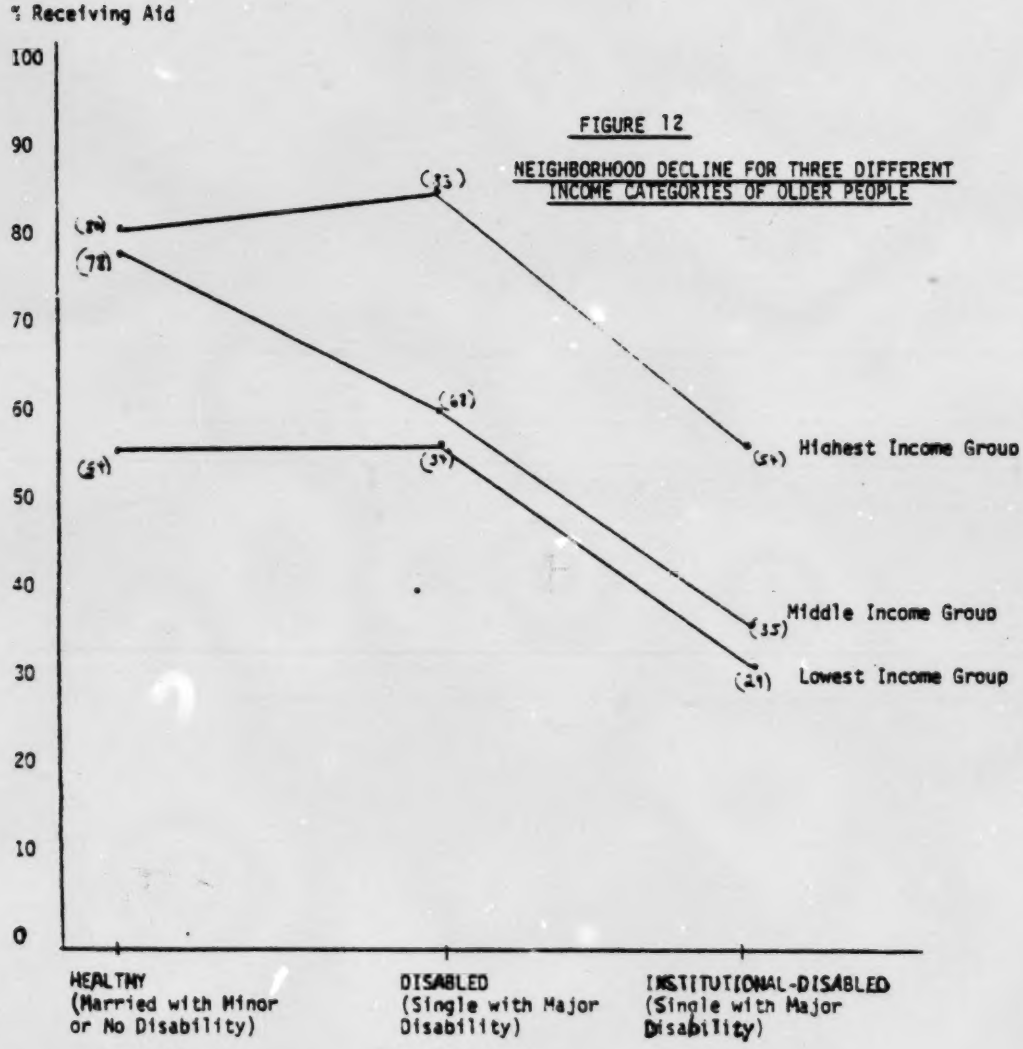

FIGURE 12

NEIGHBORHOOD DECLINE FOR THREE DIFFERENT INCOME CATEGORIES OF OLDER PEOPLE

INCOME	POPULATION		
Lowest	13	76	101
Middle	149	79	64
Highest	209	29	14

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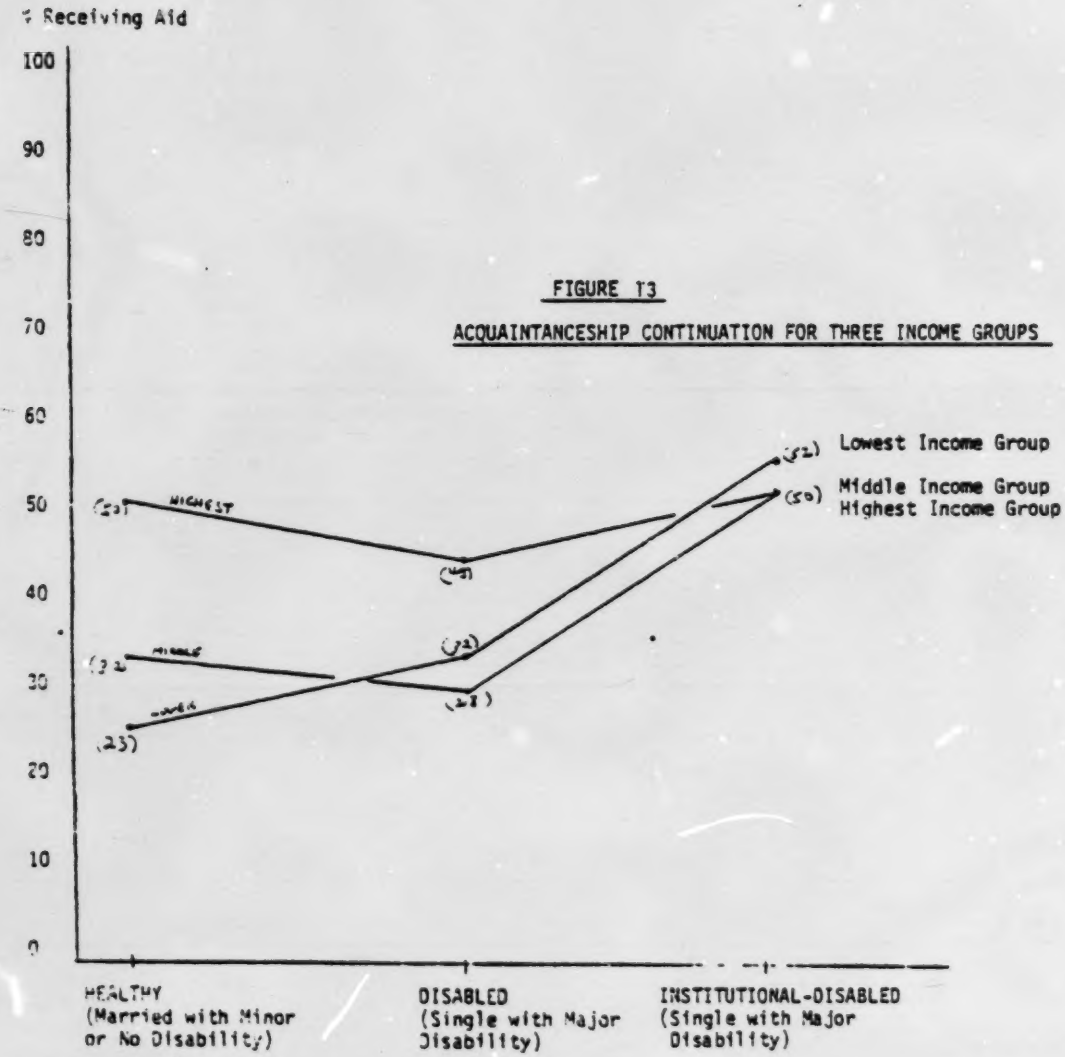
FIGURE T3

ACQUAINTANCESHIP CONTINUATION FOR THREE INCOME GROUPS



INCOME	POPULATION		
Lowest	13	76	101
Middle	149	109	64
Highest	209	29	14

BEST COPY AVAILABLE

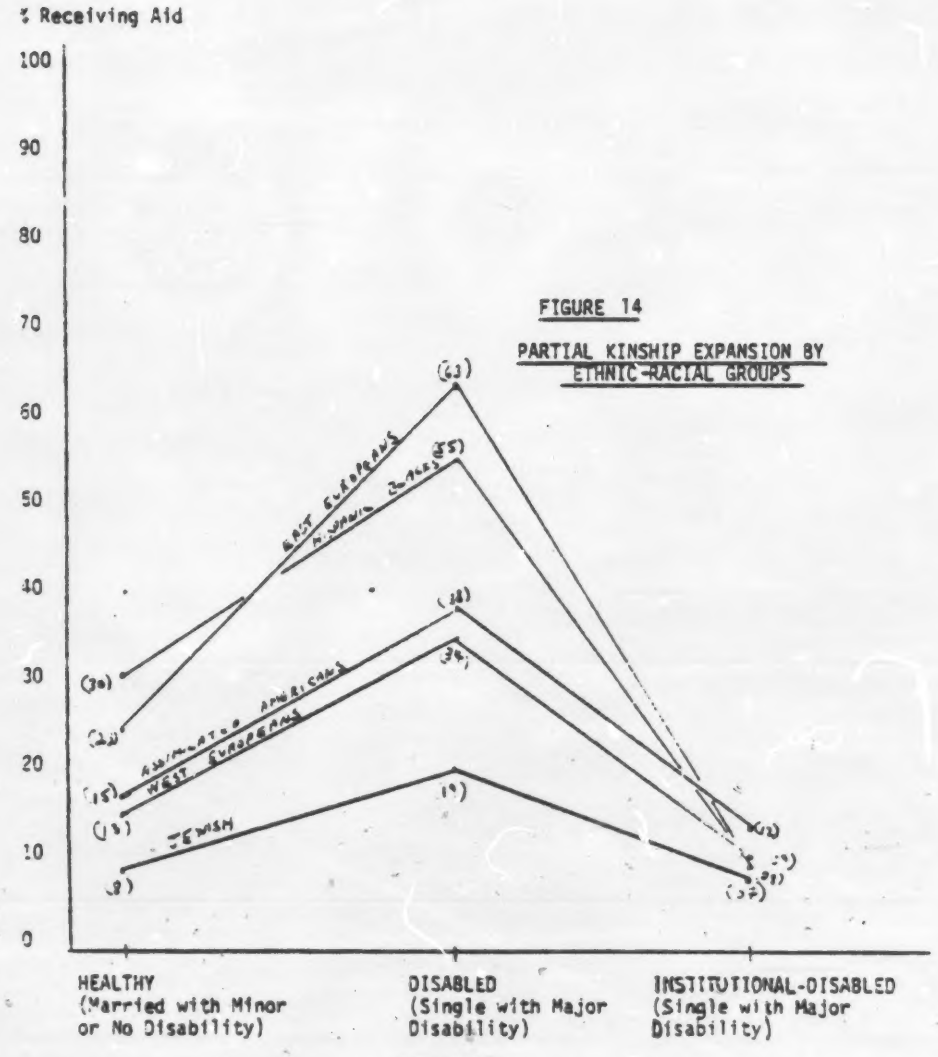


FIGURE 14

PARTIAL KINSHIP EXPANSION BY ETHNIC-RACIAL GROUPS

	POPULATION		
Hispanic-Black	58	29	31
East European	48	27	08
Assimilated	137	79	81
West European	56	43	34
Jewish	106	60	74

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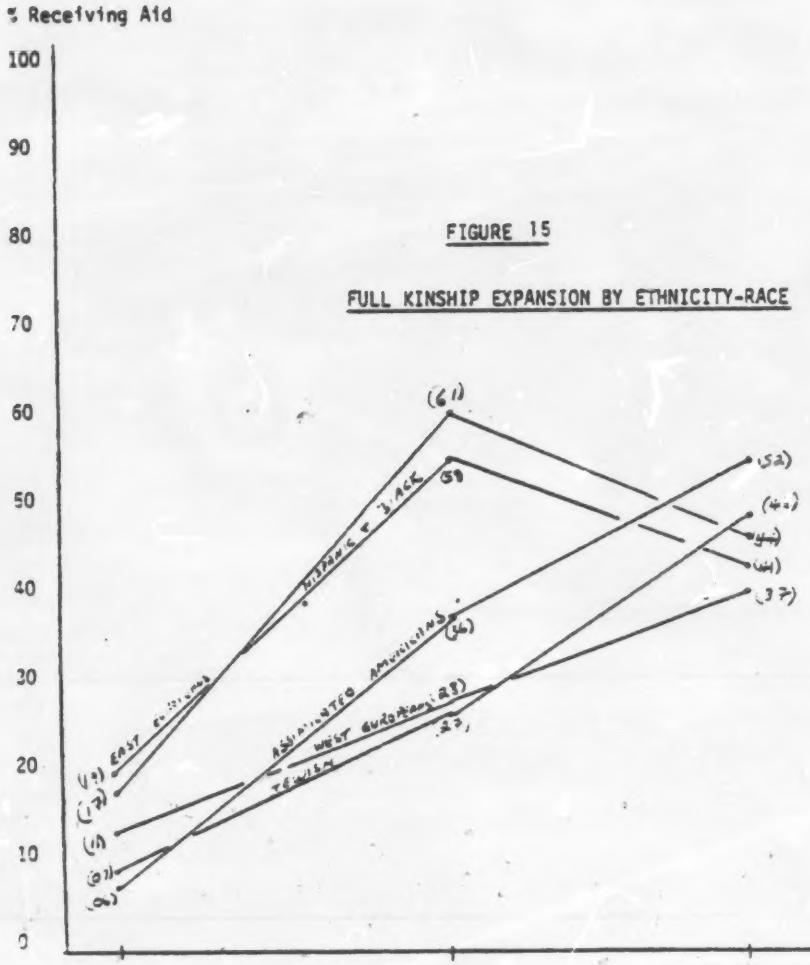

FIGURE 15

FULL KINSHIP EXPANSION BY ETHNICITY-RACE

	POPULATION		
Hispanic-Black	58	29	31
East European	48	27	03
Assimilated	137	79	31
West European	66	43	34
Jewish	106	30	21

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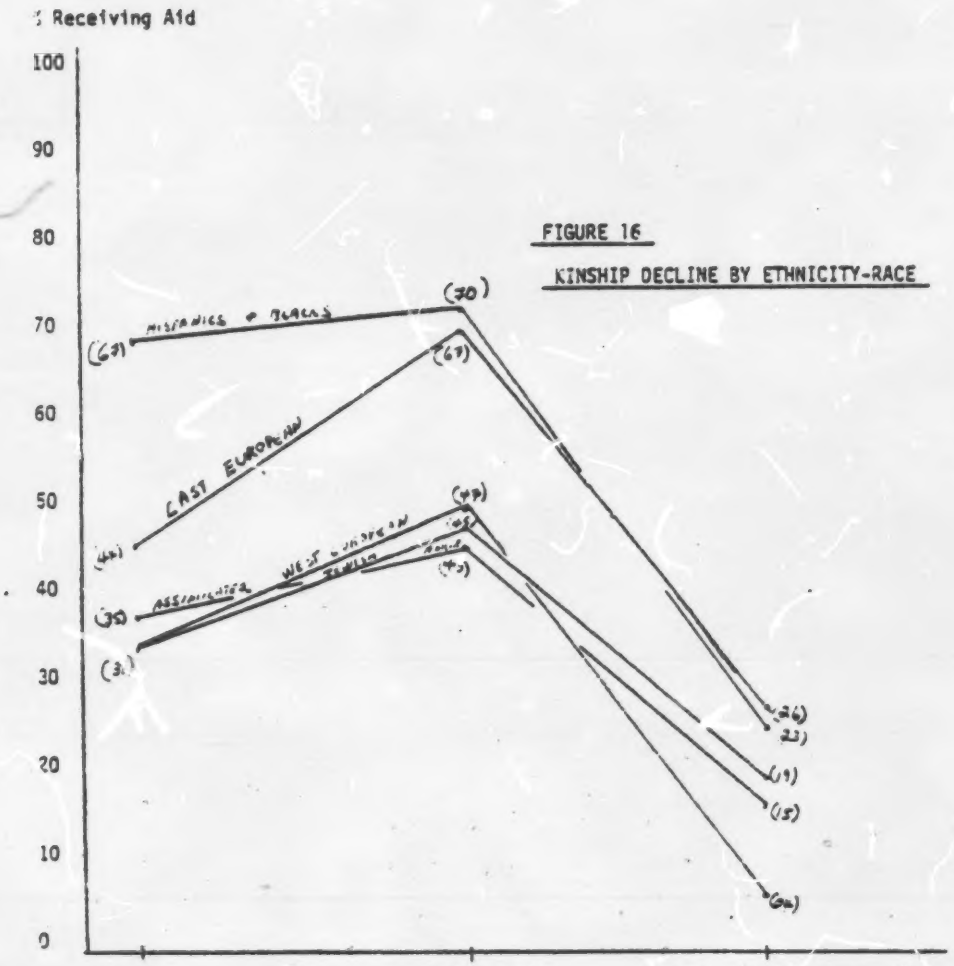

FIGURE 16

KINSHIP DECLINE BY ETHNICITY-RACE

	POPULATION		
Hispanic-Black	58	29	31
East European	48	27	28
Assimilated	137	79	81
West European	66	43	34
Jewish	106	60	74

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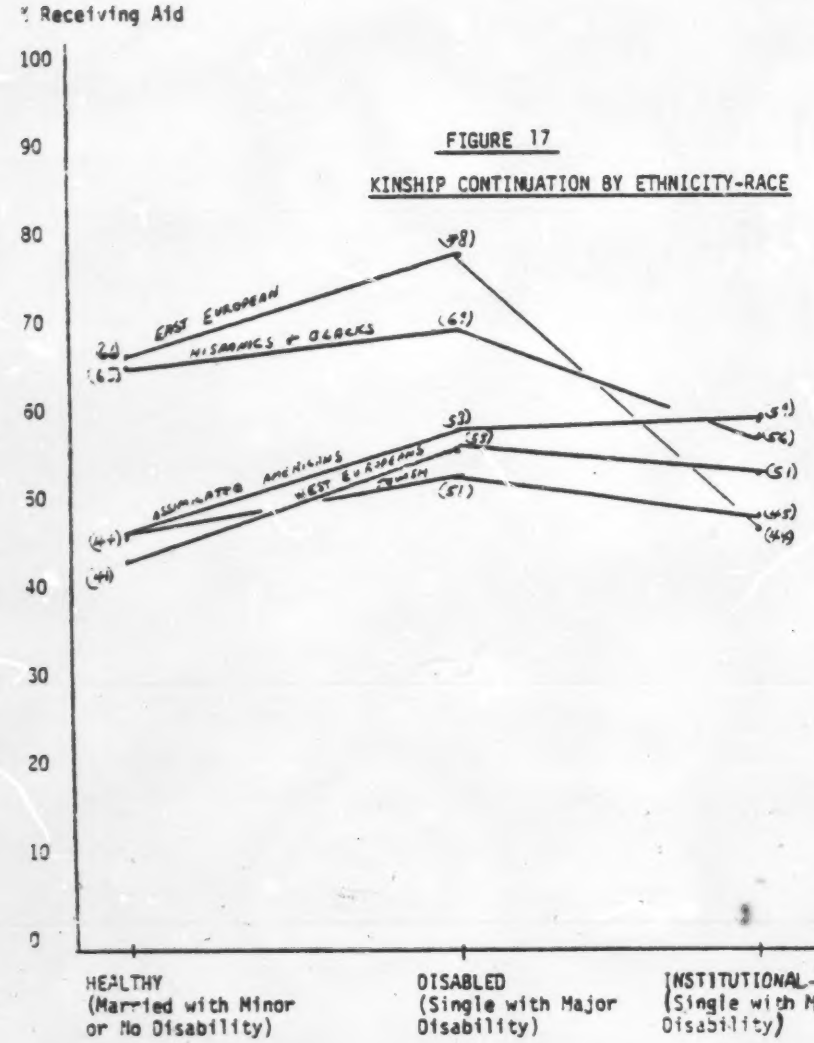

FIGURE 17

KINSHIP CONTINUATION BY ETHNICITY-RACE

	POPULATION		
Hispanic-Black	58	29	31
East European	48	27	08
Assimilated	137	79	31
West European	66	43	24
Jewish	106	60	74

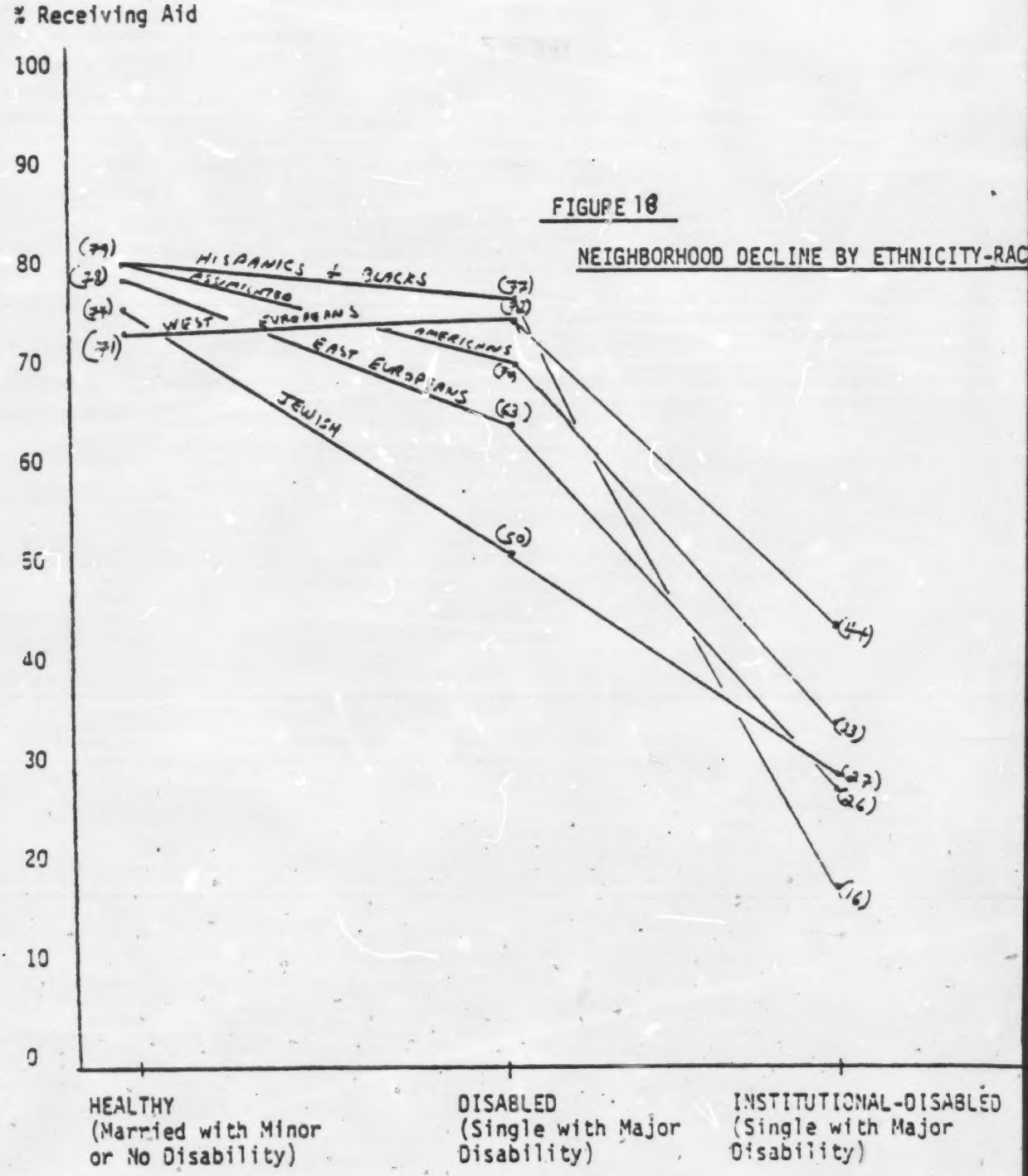

FIGURE 18

NEIGHBORHOOD DECLINE BY ETHNICITY-RAC

	POPULATION		
Hispanic-Black	58	29	31
East European	48	27	08
Assimilated	137	79	91
West European	66	43	34
Jewish	106	60	74

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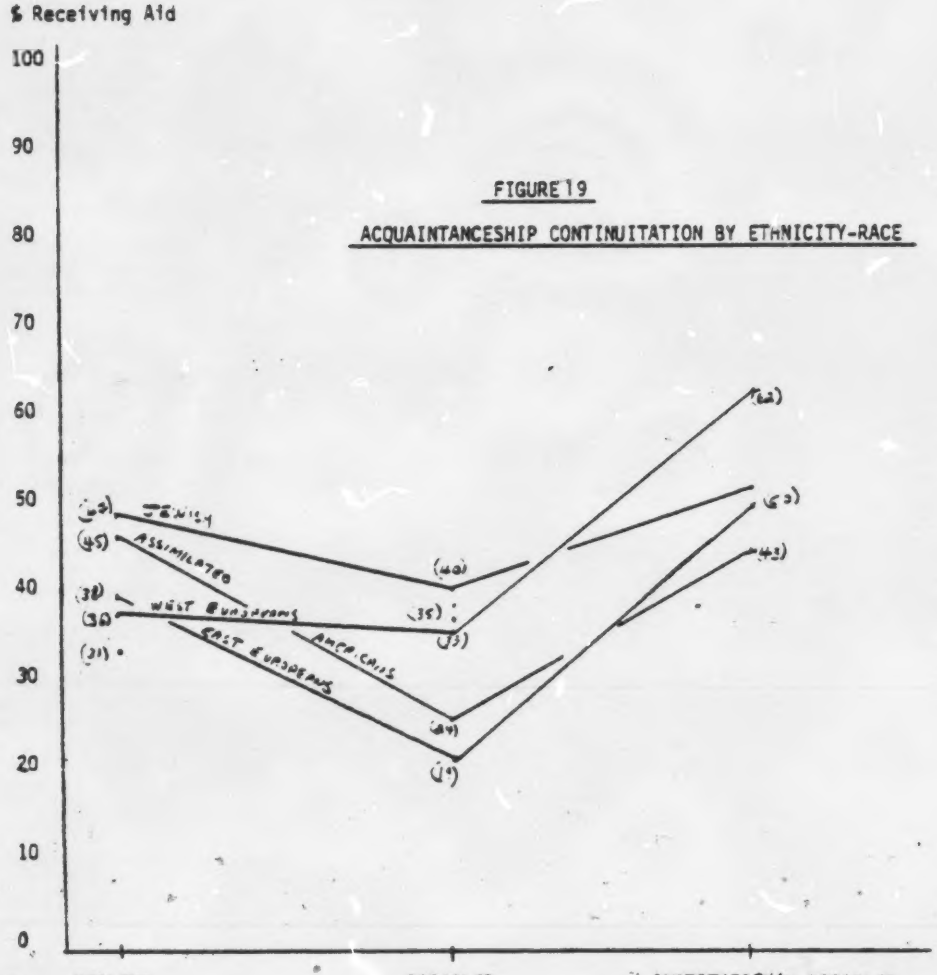
FIGURE 19

ACQUAINTANCESHIP CONTINUITATION BY ETHNICITY-RACE



	POPULATION		
Hispanic-Black	58	29	31
East European	48	27	08
Assimilated	137	79	91
West European	66	43	34
Jewish	106	60	74

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Appendix I
Exchanges Provided by Helpers for Each Stage of Disability (The Complete Population)

Exchanges provided by helpers	Stages of Disability				
	STAGE 1: Married & healthy or minor disability	STAGE 2: Married & major disability or single and minor disability	STAGE 3: Single & major disability	STAGE 4: Institutionalized and healthy or minor disability	STAGE 5: Institutionalized and major disability
Partial Kinship Expansion					
Small repairs in house	.20	.33	.41	.07	.09
Light housekeeping	.13	.21	.31	.05	.06
Full Kinship Expansion					
Keep track of bills, checks,	.14	.24	.43	.36	.51
Laundry, Cleaning, storage	.16	.21	.33	.32	.47
Kin Decline					
Check daily on aged	.47	.52	.57	.34	.23
Take care of bedridden etc.	.33	.53	.48	.14	.09
Kinship Continuation					
Take out for meal, etc.	.42	.56	.57	.47	.51
Bring small household gift	.40	.46	.47	.47	.44
Help keep in touch with rel.	.45	.46	.51	.47	.58
Cheer up when feeling low	.68	.72	.79	.80	.71
Neighborhood Decline					
Report break-in	.80	.72	.67	.35	.30
Loan salt, sugar, etc.	.74	.69	.61	.39	.20
Acquaintance Continuation					
Free time companion	.41	.47	.32	.33	.49
Population base*					
	371	590	227	154	219

* Each item has a slight variation on this base depending on the no answers, etc.

Appendix II

Regression Constants and coefficients(unstandardized) for Income and Ethnicity and Race(each a dummy variable)

Type of kin exchange	Constant health, low income, assimil-ated.	b_1 single & sick	b_2 Instit. & sick	b_3 middle income	b_4 upper income	b_5 missing income	b_6 Western Europe	b_7 Eastern Europe & Med.	b_8 Hispanic or black	b_9 Jewish	R^2
Partial kin expansion											
	.19	.27*	-.09*								.10
Small	.30	.25*	-.13*	-.11*	-.10*	-.13*					.11
repairs	.22	.28*	-.07				-.05	.08	.09	-.16*	.15
	.31	.26*	-.09*	-.10*	-.07	-.11	-.06	.08	.07	-.16*	.15
	.14	.20*	-.07*								.07
Light	.19	.19*	-.08*	-.05	-.04	-.08					.08
house-	.13	.20*	-.04				-.03	.15*	.11*	-.09*	.11
keeping	.15	.21*	-.04	-.04	.01	-.06	-.04	.16*	.11*	-.09*	.12
Full kin expansion											
Keep	.6*	.39*	.47*								.22
track of	.18	.35*	.4*	-.08*	-.13*	-.07					.23
bills &	.05	.40*	.48				-.06	.13*	.07	.02	.24
checks	.15	.36*	.43*	-.08	-.11	-.06	-.06	.12*	.05	.01	.24
	.13	.22*	.31*								.09
Laundry,	.19	.21*	.30*	-.05	-.05	-.10*					.10
cleaning,	.12	.22*	.34*				-.03	.15*	.09	-.07*	.12
storage.	.16	.22*	.34*	-.04	-.01	-.08	-.03	.15*	.09	-.07	.12
Kin decline											
	.47	.16*	-.22*								.07
Check	.52	.13*	-.24	-.01	-.07	-.08					.08
aged	.44	.16*	-.20*				-.10	.11	.25*	-.04	.12
daily	.44	.16*	-.19*	.01	.02	-.03	-.10	.11	.24*	-.04	.12
Help if	.35	.18*	-.24*								.10
bedridden	.39	.16*	-.26*	-.01	-.05	-.09					.11
2 or 3	.33	.18*	-.23*				-.04	.09	.17*	-.05	.13
weeks	.34	.18*	-.22*	.01	.004	-.06	-.04	.09	.17*	-.05	.13

(continued on next page)

Appendix II (Continued)

Type of kin exchange	Constant	b_1	b_2	b_3	b_4	b_5	b_6	b_7	b_8	b_9	R^2
Kin Continuation											
	.45	.18*	.08								.02
Takes	.51	.16*	.07	-.03	-.07	-.17*					.04
out for	.43	.19*	.11*				-.03	.22*	.09	-.08	.05
dinner	.47	.18*	.11*	-.01	-.03	-.15*	-.03	.22*	.08	-.08	.06
	.42	.09*	.04								.01
Small	.43	.08	.03	.05	-.04	-.10					.02
house	.39	.10*	.06				.009	.20*	.17*	-.10*	.05
gift	.37	.10*	.08	.07	.02	-.07	.01	.20*	.17*	-.10	.06
Keeps	.47	.06	.14*								.01
in touch	.51	.04	.12*	.03	-.07	-.05					.02
with rel-	.48	.07	.16*				-.12*	.14*	.06	-.06	.04
atives	.50	.05	.15*	.03	-.04	-.04	-.12*	.13*	.05	-.07	.04
Cheers	.72	.12*	.03								.02
up when	.78	.10*	.009	-.02	-.07	-.13*					.03
feeling	.69	.13*	.03				-.07	.11*	.08	.08*	.04
low	.73	.11*	.02	-.02	-.04	-.12	-.08	.11*	.07	.08*	.04

Population for regression was 817

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